D3

A BILL ENTITLED

AN ACT concerning

Maryland Medical Injury Compensation Reform Act

FOR the purpose of establishing a certain limitation on noneconomic damages for medical injuries for causes of action arising on and after a certain date; providing that this limitation applies in the aggregate to all claims arising from the same medical injury; requiring the itemization of certain awards and verdicts; prohibiting certain claims of subrogation relating to certain payments, reimbursements, or indemnification under certain circumstances; requiring certain alternative dispute resolution relating to health care malpractice under certain circumstances; providing for certain alternative dispute resolution procedures and costs; requiring a certain supplemental certificate of a qualified expert in a health care malpractice action under certain circumstances; providing for the contents of the supplemental certificate; requiring certain procedures concerning the supplemental certificate; providing for certain sanctions regarding health care malpractice actions if a party fails to file the supplemental certificate under certain circumstances; requiring a court to award certain costs and fees to certain prevailing parties in certain actions relating to medical review committees; altering the standard of proof for certain findings by the Board of Physicians; providing that certain provisions relating to advanced payments do not apply to certain causes of action; allowing certain parties in cases involving medical injuries to make certain offers of judgment; establishing procedures relating to offers of judgment; requiring a party who does not accept an offer of judgment to pay certain costs if the judgment obtained is not more favorable than the offer of judgment; prohibiting a jury from being informed of certain limitations; requiring a verdict of economic damages for a medical injury to exclude certain amounts for past or future medical expenses and past or future loss of earnings; providing that certain provisions relating to damages in personal injury and wrongful death cases apply to causes of action for medical injuries arising before a certain date and do not apply to causes of action for medical injuries arising on or after a certain date; establishing certain procedures and providing certain sanctions for attorneys who bring or maintain medical malpractice actions in bad faith or without substantial justification under certain circumstances; altering the number of jurors allowed in civil actions; requiring hospitals to report certain occurrences under certain circumstances; establishing a certain penalty for a violation; requiring a court to award certain costs and attorney's fees to a prevailing party in a civil action relating to certain medical review committees; altering a certain definition to provide that practice of medicine includes engaging in testimony or offering an opinion as a medical expert witness under certain circumstances; providing certain exemptions from licenses; providing that certain medical expert witnesses are subject to certain proceedings by the Board of Physicians under certain circumstances; altering a certain burden of proof

in certain proceedings by the Board of Physicians; requiring certain insurers to report certain information to the Maryland Insurance Administration under certain circumstances; requiring the Commissioner to report certain information to the Legislative Policy Committee on or before a certain date each year; abolishing the Health Claims Arbitration Office; repealing the requirement that certain claims for medical injuries must be subject to arbitration under certain circumstances; prohibiting Medical Mutual Insurance Society from denying medical liability insurance coverage to certain physicians; protecting the public welfare and assuring the continuity, affordability, and accessibility of health care for citizens of the state; stabilizing rates for medical professional liability insurance issued in the State; establishing the Maryland Medical Professional Liability Rate Stabilization Plan; providing that the Insurance Article does not apply to the Plan except as otherwise provided by this act; establishing a Board of Directors for the Plan; providing for the composition, terms, reimbursement and powers and duties of the Board; allowing the appointment of an executive director for the Plan; providing that the executive director serves at the pleasure of the Board; providing for the compensation of the executive director; authorizing the Board and the Plan to procure professional services; establishing the Maryland Medical Professional Liability Rate Stabilization Plan Fund to fund risks ceded to the Plan; providing for the administration and composition of the Fund; providing that a debt or obligation of the Plan is not a debt of the State or a pledge of credit of the State; requiring the Plan to adopt regulations that establish the terms of reinsurance agreements issued by the Plan and the standards for determining stabilized rates; establishing a People's Insurance Counsel in the Office of the Attorney General; providing for the appointment, qualifications, and compensation of the People's Insurance Counsel; requiring the Attorney General's Office to provide money in its annual budget for the People's Insurance Counsel; authorizing People's Insurance Counsel to retain certain experts; providing for the cross examination of witnesses at medical professional liability rate hearings; limiting the right of cross examination; requiring the Maryland Insurance Commissioner to collect a certain assessment from medical professional liability insurer and pay the amounts collected to the Office of the Attorney General; establishing the duties of People's Insurance Counsel; establishing that People's Insurance Counsel will be considered to be an aggrieved person for purposes of medical professional liability rate filings; defining certain terms; making stylistic changes; requiring a certain notification by the Director of the Health Claims Arbitration Office when there are no claims pending before the Office under certain circumstances; requiring the Health Services Cost Review Commission to include a certain reasonable amount of additional funding in hospital approved rates for hospital patient safety related initiatives and infrastructure under certain circumstances; prohibiting certain providers of health benefit plans from reimbursing certain health care providers in less than certain amounts under certain circumstances; providing for the application of this Act; providing for the termination of certain provisions of this Act; making the provisions of this Act severable; providing for the effective dates of certain provisions of this Act; making provisions of this Act an emergency measure; and generally relating to medical injury compensation reform.

BY repealing and reenacting, with amendments,
Article - Courts and Judicial Proceedings
Section 3-2A-01, 3-2A-02(d), 3-2A-08, 8-306, 11-108(c), and 11-109(c) and (d)

Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY repealing
Article - Courts and Judicial Proceedings
Section 3-2A-01(b) and 3-2A-03 through 3-2A-07, inclusive
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY adding to
Article - Courts and Judicial Proceedings
Section 3-2A-02(d) and (e), 3-2A-06C, 3-2A-06D, 3-2A-06E, 3-2A-7A, 3-2A-08A, 3-2A-09, 3-2A-10, 11-108(e), and 11-109(d) and (e)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY renumbering
Article - Courts and Judicial Proceedings
Section 3-2A-01(c) through (l), respectively, to be 3-2A-01(b) through (k), respectively
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)
(As enacted by Section 1 of this Act)

BY repealing and reenacting, with amendments,
Article - Courts and Judicial Proceedings
Section 3-2A-08 and 11-108(d)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)
(As enacted by Section 1 of this Act)

BY repealing
Article - Courts and Judicial Proceedings
Section 11-108(c) and 11-109(d)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)
(As enacted by Section 1 of this Act)

BY adding to
Article - Health-General
Section 19-319(i)

Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Health Occupations
Section 1-401, 14-101(l)(1), 14-302, 14-401, and 14-405
Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY adding to
Article - Health Occupations
Section 14-404.1
Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 1-202(3)(vii) and (4)(xii), 2-213, 4-401, and 19-104
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY adding to
Article - Insurance
Section 1-202(5), 4-401, 29-101 through 29-502, inclusive, to be under the new title "Title 29. Maryland Medical Professional Liability Rate Stabilization Plan", and 24-209(c)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments
Article - State Finance and Procurement
Section 11-203(a)(1)(xix)
Annotated Code of Maryland
(2001 Replacement Volume and 2004 Supplement)

BY adding to
Article - State Finance and Procurement
Section 11-203(a)(1)(xx)
Annotated Code of Maryland
(2001 Replacement Volume and 2004 Supplement)

BY adding to

Article - State Government
Section 6-301 through 6-305, inclusive, to be under the new subtitle "Subtitle 3. People's Insurance Counsel"
Annotated Code of Maryland
(1999 Replacement Volume and 2004 Supplement)

Preamble

WHEREAS, Access to affordable medical malpractice insurance by health care providers such as physicians, hospitals, nursing homes, assisted living facilities, continuing care communities, osteopaths, optometrists, chiropractors, nurses, dentists, podiatrists, psychologists, social workers, physical therapists, medical day care centers, and hospice care programs is critical to Maryland's nationally recognized health care delivery system; and

WHEREAS, When medical malpractice insurance becomes unaffordable or unavailable for health care providers, critical health care services become restricted or even unavailable and the quality of medical care available to Maryland patients is diminished; and

WHEREAS, Maryland has taken significant steps in establishing patient safety and provider accountability, including establishment of a hospital report card system, and a Patient Safety Coalition to promote patient safety awareness and education, the sharing of best practices, and the strengthening of oversight of adverse medical events; and

WHEREAS, Nationally and in Maryland malpractice premiums and costs have skyrocketed and malpractice insurance is becoming unaffordable and unavailable in the State; and

WHEREAS, Excessive premiums for medical malpractice insurance divert needed resources away from patient care and are a drain on the State budget; and

WHEREAS, Legislative reforms are needed to ensure the continued availability and affordability of medical malpractice insurance for health care providers and the provision of health care services in the State; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Courts and Judicial Proceedings

3-2A-01.

(a) In this subtitle the following terms have the meanings indicated unless the context of their use requires otherwise.

(b) "Arbitration panel" means the arbitrators selected to determine a health care malpractice claim in accordance with this subtitle.

(C) "ALTERNATIVE DISPUTE RESOLUTION" MEANS MEDIATION, NEUTRAL CASE EVALUATION, NEUTRAL FACT-FINDING, OR A SETTLEMENT CONFERENCE.

[(c)] (D) "Court" means a circuit court for a county.

[(d)] (E) "Director" means the Director of the Health Claims Arbitration Office.

(F) "ECONOMIC DAMAGES" RETAINS ITS JUDICIALLY DETERMINED MEANING.

[(e)] (G) (1) "Health care provider" means a hospital, a related institution as defined in § 19-301 of the Health - General Article, A MEDICAL DAY CARE CENTER, A HOSPICE CARE PROGRAM, AN ASSISTED LIVING PROGRAM, A FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B- 01 OF THE HEALTH-GENERAL ARTICLE, a physician, an osteopath, an optometrist, a chiropractor, a registered or licensed practical nurse, a dentist, a podiatrist, a psychologist, a licensed certified social worker-clinical, and a physical therapist, licensed or authorized to provide one or more health care services in Maryland.

(2) "Health care provider" does not [mean] INCLUDE any nursing institution conducted by and for those who rely upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination.

(H) "MEDIATION", "NEUTRAL CASE EVALUATION", "NEUTRAL FACT FINDING", AND "SETTLEMENT CONFERENCE" HAVE THE MEANINGS STATED IN TITLE 17 OF THE MARYLAND RULES.

(I) "MEDIATOR" MEANS AN INDIVIDUAL WHO CONDUCTS MEDIATION.

(J) "MEDICAL EXPENSES" MEANS ANY COSTS THAT HAVE BEEN OR WILL BE INCURRED BY OR ON BEHALF OF THE CLAIMANT AS A RESULT OF A MEDICAL INJURY, INCLUDING THE COSTS OF MEDICAL AND HOSPITAL, REHABILITATIVE, RESIDENTIAL AND CUSTODIAL CARE AND SERVICE, SPECIAL EQUIPMENT OR FACILITIES, AND RELATED TRAVEL.

[(f)] (K) "Medical injury" means injury arising or resulting from the rendering or failure to render

health care.

(L) “NEUTRAL PROVIDER” MEANS AN INDIVIDUAL FACILITATOR WHO CONDUCTS NEUTRAL CASE EVALUATION, NEUTRAL FACT FINDING, OR A SETTLEMENT CONFERENCE.

(M) "NONECONOMIC DAMAGES" MEANS:

(1) IN A CLAIM FOR PERSONAL INJURY, PAIN, SUFFERING, INCONVENIENCE, PHYSICAL IMPAIRMENT, DISFIGUREMENT, LOSS OF CONSORTIUM, OR OTHER NONPECUNIARY INJURY; OR

(2) IN A CLAIM FOR WRONGFUL DEATH, MENTAL ANGUISH, EMOTIONAL PAIN AND SUFFERING, LOSS OF SOCIETY, COMPANIONSHIP, COMFORT, PROTECTION, CARE, MARITAL CARE, PARENTAL CARE, FILIAL CARE, ATTENTION, ADVICE, COUNSEL, TRAINING, GUIDANCE, OR EDUCATION, OR OTHER NONECONOMIC DAMAGES AUTHORIZED UNDER SUBTITLE 9 OF THIS TITLE.

3-2A-02.

(D) (1) THIS SUBSECTION APPLIES TO AN INITIAL COMPLAINT FILED IN COURT ON OR AFTER JANUARY 1, 2005.

(2) (I) IN ADDITION TO ANY OTHER QUALIFICATIONS, A HEALTH CARE PROVIDER SIGNING A CERTIFICATE OF QUALIFIED EXPERT OR TESTIFYING IN RELATION TO A PROCEEDING BEFORE A COURT CONCERNING COMPLIANCE WITH OR DEPARTURE FROM STANDARDS OF CARE:

1. SHALL HAVE HAD ACTIVE CLINICAL EXPERIENCE, PROVIDED CONSULTATION RELATING TO ACTIVE CLINICAL PRACTICE, OR TAUGHT MEDICINE IN EITHER THE DEFENDANT’S SPECIALTY OR A RELATED FIELD OF MEDICINE WITHIN ONE YEAR OF THE DATE OF THE ALLEGED ACT OR OMISSION GIVING RISE TO THE CAUSE OF ACTION; AND

2. EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, IF THE DEFENDANT IS BOARD CERTIFIED IN A SPECIALTY, SHALL BE BOARD CERTIFIED IN THE SAME OR A RELATED SPECIALTY AS THE DEFENDANT.

(II) SUBPARAGRAPH (I)2 OF THIS PARAGRAPH DOES NOT APPLY IF

THE DEFENDANT WAS PROVIDING CARE OR TREATMENT UNRELATED TO THE AREA IN WHICH THE DEFENDANT IS BOARD CERTIFIED.

(3) A HEALTH CARE PROVIDER ATTESTING TO A CERTIFICATE OF QUALIFIED EXPERT UNDER § 3-2A-06C OF THIS SUBTITLE OR TESTIFYING IN RELATION TO A PROCEEDING BEFORE A COURT CONCERNING COMPLIANCE WITH OR DEPARTURE FROM STANDARDS OF CARE MAY NOT DEVOTE ANNUALLY MORE THAN 20 PERCENT OF THE EXPERT'S PROFESSIONAL ACTIVITIES TO ACTIVITIES THAT LEAD OR COULD LEAD TO TESTIMONY IN PERSONAL INJURY CLAIMS IF THE ACTIVITIES ARE UNRELATED TO THE CARE OR TREATMENT OF A PATIENT.

(E) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, IN AN ACTION AGAINST A HEALTH CARE PROVIDER UNDER THIS SUBTITLE FOR A CAUSE OF ACTION ARISING ON OR AFTER JANUARY 1, 2005, ANY STATEMENT, AFFIRMATION, GESTURE, OR CONDUCT EXPRESSING APOLOGY, SYMPATHY, COMMISERATION, CONDOLENCE, COMPASSION, OR A GENERAL SENSE OF BENEVOLENCE WHICH IS MADE BY A HEALTH CARE PROVIDER OR AN AGENT OR EMPLOYEE OF A HEALTH CARE PROVIDER TO THE ALLEGED VICTIM OR A RELATIVE, FRIEND, REPRESENTATIVE, OR ASSOCIATE OF THE ALLEGED VICTIM AND WHICH RELATES TO THE DISCOMFORT, PAIN, SUFFERING, INJURY, OR DEATH OF THE ALLEGED VICTIM AS THE RESULT OF A MEDICAL INJURY SHALL BE INADMISSIBLE AS EVIDENCE OF AN ADMISSION OF LIABILITY OR AS EVIDENCE OF AN ADMISSION AGAINST INTEREST.

(2) AN ADMISSION OF LIABILITY OR FAULT WHICH IS PART OF OR IN ADDITION TO A COMMUNICATION MADE UNDER PARAGRAPH (1) OF THIS SUBSECTION IS ADMISSIBLE IN EVIDENCE AS AN ADMISSION OF LIABILITY OR EVIDENCE OF AN ADMISSION AGAINST INTEREST IN AN ACTION UNDER THIS SUBTITLE.

[(d)] (F) Except as otherwise provided, the Maryland Rules shall apply to all practice and procedure issues arising under this subtitle.

3-2A-06C.

(A) THIS SECTION APPLIES TO AN INITIAL COMPLAINT FILED ON OR AFTER JANUARY 1, 2005, BY A PERSON AGAINST A HEALTH CARE PROVIDER FOR MEDICAL INJURY IN WHICH DAMAGES OF MORE THAN THE LIMIT OF THE CONCURRENT JURISDICTION OF THE DISTRICT COURT ARE SOUGHT.

(B) (1) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SUBTITLE, A PERSON SHALL COMMENCE AN ACTION AGAINST A HEALTH CARE PROVIDER FOR A MEDICAL INJURY BY FILING A COMPLAINT IN COURT IN ACCORDANCE WITH THE MARYLAND RULES.

(2) (I) THE CLERK OF THE COURT SHALL FORWARD A COPY OF A COMPLAINT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(II) IF THE COMPLAINT INVOLVES A PHYSICIAN, THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHALL FORWARD A COPY OF THE COMPLAINT TO THE STATE BOARD OF PHYSICIANS.

(C) UNLESS THE SOLE ISSUE IN THE CLAIM IS LACK OF INFORMED CONSENT:

(1) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, ON MOTION OF A DEFENDANT AN ACTION MAY BE DISMISSED, WITHOUT PREJUDICE, IF THE PLAINTIFF FAILS TO FILE WITH THE COURT WITHIN 90 DAYS FROM THE DATE OF THE COMPLAINT FOR EACH DEFENDANT A CERTIFICATE OF A QUALIFIED EXPERT ATTESTING TO DEPARTURE FROM STANDARDS OF CARE, AND THAT THE DEPARTURE FROM STANDARDS OF CARE IS THE PROXIMATE CAUSE OF THE ALLEGED INJURY.

(II) IN LIEU OF DISMISSING THE CLAIM, THE COURT SHALL GRANT AN EXTENSION OF NO MORE THAN 90 DAYS FOR FILING THE CERTIFICATE REQUIRED BY THIS PARAGRAPH, IF:

1. THE LIMITATIONS PERIOD APPLICABLE TO THE ACTION HAS EXPIRED; AND

2. THE FAILURE TO FILE THE CERTIFICATE WAS NEITHER WILLFUL NOR THE RESULT OF GROSS NEGLIGENCE.

(2) ON MOTION OF A PLAINTIFF AN ACTION MAY BE ADJUDICATED IN FAVOR OF THE PLAINTIFF ON THE ISSUE OF LIABILITY, IF THE DEFENDANT DISPUTES LIABILITY AND FAILS TO FILE A CERTIFICATE OF A QUALIFIED EXPERT ATTESTING TO COMPLIANCE WITH STANDARDS OF CARE, OR THAT THE DEPARTURE FROM STANDARDS OF CARE IS NOT THE PROXIMATE CAUSE OF THE ALLEGED INJURY, WITHIN 120 DAYS FROM THE DATE THE PLAINTIFF SERVED THE CERTIFICATE OF A QUALIFIED EXPERT SET FORTH IN PARAGRAPH (1) OF THIS SUBSECTION ON THE DEFENDANT.

(III) IF THE DEFENDANT DOES NOT DISPUTE LIABILITY, A CERTIFICATE OF A QUALIFIED EXPERT IS NOT REQUIRED UNDER THIS SUBSECTION.

(3) DISCOVERY IS AVAILABLE AS TO THE BASIS OF THE CERTIFICATE.

(D) (1) (I) THIS SUBSECTION APPLIES ONLY TO AN ACTION FOR WHICH A CERTIFICATE OF A QUALIFIED EXPERT IS REQUIRED TO BE FILED UNDER THIS SECTION.

(II) THIS SUBSECTION DOES NOT APPLY IF THE DEFENDANT ADMITS LIABILITY.

(2) (I) WITHIN 15 DAYS AFTER THE DATE THAT DISCOVERY IS REQUIRED TO BE COMPLETED, A PARTY SHALL FILE WITH THE COURT A SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT THAT ATTESTS TO:

1. THE CERTIFYING EXPERT'S BASIS FOR ALLEGING WHAT IS THE SPECIFIC STANDARD OF CARE;

2. THE CERTIFYING EXPERT'S QUALIFICATIONS TO TESTIFY TO THE SPECIFIC STANDARD OF CARE;

3. THE SPECIFIC STANDARD OF CARE;

4. FOR THE PLAINTIFF:

A. THE SPECIFIC INJURY COMPLAINED OF;

B. HOW THE SPECIFIC STANDARD OF CARE WAS BREACHED;

C. WHAT SPECIFICALLY THE DEFENDANT SHOULD HAVE DONE TO MEET THE SPECIFIC STANDARD OF CARE; AND

D. THE INFERENCE THAT THE BREACH OF THE STANDARD OF CARE PROXIMATELY CAUSED THE PLAINTIFF'S INJURY; AND

5. FOR THE DEFENDANT:

A. HOW THE DEFENDANT COMPLIED WITH THE

SPECIFIC STANDARD OF CARE;

B. WHAT THE DEFENDANT DID TO MEET THE SPECIFIC STANDARD OF CARE; AND

C. IF APPLICABLE, THAT THE BREACH OF THE STANDARD OF CARE PROXIMATELY DID NOT CAUSE THE PLAINTIFF'S INJURY.

(II) AN EXTENSION OF THE TIME ALLOWED FOR FILING A SUPPLEMENTAL CERTIFICATE UNDER THIS SECTION SHALL BE GRANTED FOR GOOD CAUSE SHOWN.

(III) THE FACTS REQUIRED TO BE INCLUDED IN THE SUPPLEMENTAL CERTIFICATE SHALL BE CONSIDERED NECESSARY TO SHOW ENTITLEMENT TO RELIEF SOUGHT BY A PLAINTIFF OR TO RAISE A DEFENSE BY A DEFENDANT.

(3) SUBJECT TO THE PROVISIONS OF THIS SECTION:

(I) IF THE PLAINTIFF FAILS TO FILE A SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT, ON MOTION OF THE DEFENDANT THE COURT SHALL DISMISS WITH PREJUDICE THE ACTION; OR

(2) IF THE DEFENDANT FAILS TO FILE A SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT, ON MOTION OF THE PLAINTIFF THE COURT SHALL ADJUDICATE IN FAVOR OF THE PLAINTIFF ON THE ISSUE OF LIABILITY.

(E) (1) THE MARYLAND RULES APPLY TO FILING AND SERVING A COPY OF A CERTIFICATE REQUIRED UNDER THIS SECTION AND IN MOTIONS RELATING TO A VIOLATION OF THIS SECTION.

(2) NOTHING CONTAINED IN THIS SECTION PROHIBITS OR LIMITS A PARTY FROM MOVING FOR SUMMARY JUDGMENT IN ACCORDANCE WITH THE MARYLAND RULES.

(F) FOR PURPOSES OF THE CERTIFICATION REQUIREMENTS OF THIS SECTION:

(1) A PARTY MAY NOT SERVE AS A PARTY'S EXPERT; AND

(2) THE CERTIFICATE MAY NOT BE SIGNED BY:

(I) A PARTY;

(II) AN EMPLOYEE OR PARTNER OF A PARTY; OR

(III) AN EMPLOYEE OR STOCKHOLDER OF ANY PROFESSIONAL CORPORATION OF WHICH THE PARTY IS A STOCKHOLDER.

(G) (1) THE CLERK OF THE COURT SHALL FORWARD TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE COPIES OF THE CERTIFICATES FILED UNDER THIS SECTION.

(2) IN THE CASE OF A CLAIM AGAINST A PHYSICIAN, THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHALL FORWARD COPIES OF THE CERTIFICATES FILED UNDER THIS SECTION TO THE STATE BOARD OF PHYSICIANS.

3-2A-06D.

(A) THIS SECTION APPLIES TO A COMPLAINT FILED UNDER § 3-2A-06C OF THIS SUBTITLE.

(B) THE TRIER OF FACT SHALL ITEMIZE THE VERDICT TO REFLECT THE MONETARY AMOUNT INTENDED FOR ANY OF THE FOLLOWING DAMAGES THAT ARE APPLICABLE TO THE ACTION:

(1) PAST MEDICAL EXPENSES;

(2) FUTURE MEDICAL EXPENSES;

(3) PAST LOSS OF EARNINGS;

(4) FUTURE LOSS OF EARNINGS;

(5) PAST PECUNIARY LOSS;

(6) FUTURE PECUNIARY LOSS;

(7) OTHER PAST ECONOMIC DAMAGES;

(8) OTHER FUTURE ECONOMIC DAMAGES; AND

(9) NONECONOMIC DAMAGES.

(C) (1) A PARTY FILING A MOTION FOR A NEW TRIAL MAY OBJECT TO THE DAMAGES AS EXCESSIVE ON THE GROUND THAT THE PLAINTIFF HAS BEEN OR WILL BE PAID, REIMBURSED, OR INDEMNIFIED OR HAS RECEIVED OR WILL RECEIVE CARE OR BENEFITS UNDER LAW, INSURANCE, OR CONTRACT.

(2) THE COURT SHALL HOLD A HEARING AND RECEIVE EVIDENCE IN SUPPORT AND OPPOSITION TO A REQUEST FOR REDUCTION, INCLUDING EVIDENCE OF THE COST TO OBTAIN THE PAYMENT, REIMBURSEMENT, OR INDEMNITY.

(3) (I) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, IF THE COURT FINDS FROM THE EVIDENCE THAT THE DAMAGES ARE EXCESSIVE ON THE GROUNDS STATED IN PARAGRAPH (1) OF THIS SUBSECTION IT MAY GRANT A NEW TRIAL AS TO THE DAMAGES OR MAY DENY A NEW TRIAL IF THE PLAINTIFF AGREES TO A REMITTITUR OF THE EXCESS.

(II) IN THE EVENT OF A NEW TRIAL GRANTED UNDER THIS SUBSECTION, EVIDENCE CONSIDERED BY THE COURT IN GRANTING THE REMITTITUR SHALL BE ADMISSIBLE IF OFFERED AT THE NEW TRIAL AND THE JURY SHALL BE INSTRUCTED TO CONSIDER SUCH EVIDENCE IN REACHING ITS VERDICT AS TO DAMAGES.

(III) ON A DETERMINATION OF THOSE DAMAGES AT THE NEW TRIAL, NO FURTHER OBJECTION TO DAMAGES MAY BE MADE EXCLUSIVE OF ANY PARTY'S RIGHT OF APPEAL .

(4) A VERDICT MAY NOT BE MODIFIED AS TO ANY SUMS PAID OR PAYABLE TO A CLAIMANT UNDER ANY WORKERS' COMPENSATION ACT, CRIMINAL INJURIES COMPENSATION ACT, EMPLOYEE BENEFIT PLAN ESTABLISHED UNDER A COLLECTIVE BARGAINING AGREEMENT BETWEEN AN EMPLOYER AND AN EMPLOYEE OR A GROUP OF EMPLOYERS AND A GROUP OF EMPLOYEES THAT IS SUBJECT TO THE PROVISIONS OF THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, OR AS A BENEFIT UNDER ANY CONTRACT OR POLICY OF LIFE INSURANCE OR SOCIAL SECURITY ACT OF THE UNITED STATES.

(5) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, EXCEPT AS EXPRESSLY PROVIDED BY FEDERAL LAW, NO PERSON MAY RECOVER FROM THE PLAINTIFF OR ASSERT A CLAIM OF SUBROGATION AGAINST A DEFENDANT FOR ANY SUM INCLUDED IN A REMITTITUR OR AWARDED IN A NEW TRIAL ON DAMAGES GRANTED UNDER THIS SUBSECTION.

(6) NOTHING IN THIS SUBSECTION SHALL BE CONSTRUED TO OTHERWISE LIMIT THE COMMON LAW GROUNDS FOR REMITTITUR.

3-2A-06E.

(A) (1) THIS SECTION DOES NOT APPLY IF:

(I) ALL PARTIES FILE WITH THE COURT AN AGREEMENT NOT TO ENGAGE IN ALTERNATIVE DISPUTE RESOLUTION; AND

(II) THE COURT FINDS THAT ALTERNATIVE DISPUTE RESOLUTION UNDER THIS SECTION WOULD NOT BE PRODUCTIVE.

(2) IN DETERMINING WHETHER ALTERNATIVE DISPUTE RESOLUTION WOULD NOT BE PRODUCTIVE UNDER PARAGRAPH (1)(II) OF THIS SUBSECTION, THE COURT MAY CONSIDER WHETHER THE PARTIES HAVE ALREADY ENGAGED IN ALTERNATIVE DISPUTE RESOLUTION.

(B) IN ADDITION TO THE QUALIFICATIONS AND REQUIREMENTS OF TITLE 17 OF THE MARYLAND RULES, THE COURT OF APPEALS MAY ADOPT RULES REQUIRING A MEDIATOR OR NEUTRAL PROVIDER TO HAVE EXPERIENCE WITH HEALTH CARE MALPRACTICE CLAIMS.

(C) WITHIN 30 DAYS OF THE LATTER OF THE FILING OF A DEFENDANT'S ANSWER TO THE COMPLAINT OR CERTIFICATE OF QUALIFIED EXPERT, THE COURT SHALL ORDER THE PARTIES TO ENGAGE IN ALTERNATIVE DISPUTE RESOLUTION AT THE EARLIEST POSSIBLE DATE.

(D) (1) WITHIN 30 DAYS OF THE LATTER OF THE FILING OF A DEFENDANT'S ANSWER TO THE COMPLAINT OR CERTIFICATE OF QUALIFIED EXPERT UNDER § 3-2A-06C OF THIS SUBTITLE, THE PARTIES MAY CHOOSE A MEDIATOR OR NEUTRAL PROVIDER.

(2) IF THE PARTIES CHOOSE A MEDIATOR OR NEUTRAL PROVIDER, THE PARTIES SHALL NOTIFY THE COURT OF THE NAME OF THE INDIVIDUAL.

(E) (1) IF THE PARTIES DO NOT NOTIFY THE COURT THAT THEY HAVE CHOSEN A MEDIATOR OR NEUTRAL PROVIDER WITHIN THE TIME REQUIRED UNDER SUBSECTION (D) OF THIS SECTION, THE COURT SHALL ASSIGN A MEDIATOR OR NEUTRAL PROVIDER TO THE CLAIM WITHIN 30 DAYS.

(2) (I) WITHIN 15 DAYS AFTER THE PARTIES ARE NOTIFIED OF THE IDENTITY OF THE MEDIATOR OR NEUTRAL PROVIDER, A PARTY MAY OBJECT IN WRITING TO THE SELECTION, STATING THE REASONS FOR THE OBJECTION.

(II) IF THE COURT SUSTAINS THE OBJECTION THE COURT SHALL APPOINT A DIFFERENT MEDIATOR OR NEUTRAL PROVIDER.

(3) A MEDIATOR OR NEUTRAL PROVIDER SHALL FOLLOW THE "MARYLAND STANDARDS OF PRACTICE FOR MEDIATORS, ARBITRATORS AND OTHER ADR PRACTITIONERS" ADOPTED BY THE COURT OF APPEALS.

(F) THE MEDIATOR OR NEUTRAL PROVIDER SHALL SCHEDULE AN INITIAL CONFERENCE WITH THE PARTIES AS SOON AS PRACTICABLE.

(G) (1) AT LEAST 15 DAYS BEFORE THE INITIAL CONFERENCE, THE PARTIES SHALL SEND THE MEDIATOR OR NEUTRAL PROVIDER A BRIEF WRITTEN OUTLINE OF THE STRENGTHS AND WEAKNESSES OF THEIR RESPECTIVE CASES.

(2) A PARTY MAY NOT BE REQUIRED TO PROVIDE TO ANOTHER PARTY THE WRITTEN OUTLINE DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION.

(H) (1) ALTERNATIVE DISPUTE RESOLUTION UNDER THIS SECTION MAY NOT OPERATE TO DELAY DISCOVERY IN THE ACTION.

(2) IF THE MEDIATOR OR NEUTRAL PROVIDER AT THE INITIAL CONFERENCE FINDS THAT THE PARTIES NEED TO ENGAGE IN DISCOVERY FOR A LIMITED PERIOD OF TIME IN ORDER TO FACILITATE THE ALTERNATIVE DISPUTE RESOLUTION, THE MEDIATOR OR NEUTRAL PROVIDER MAY MEDIATE THE SCOPE AND SCHEDULE OF THE DISCOVERY NEEDED TO PROCEED WITH THE ALTERNATIVE DISPUTE RESOLUTION, ADJOURN THE INITIAL CONFERENCE, AND RESCHEDULE AN ADDITIONAL CONFERENCE FOR A LATER DATE.

(I) A NEUTRAL EXPERT MAY BE EMPLOYED IN ALTERNATIVE DISPUTE RESOLUTION UNDER THIS SECTION AS PROVIDED IN TITLE 17 OF THE MARYLAND RULES.

(J) IN ACCORDANCE WITH MARYLAND RULE 17-109, THE OUTLINE DESCRIBED IN SUBSECTION (G) OF THIS SECTION AND ANY WRITTEN OR ORAL COMMUNICATION MADE IN CONNECTION WITH A CONFERENCE UNDER THIS

SECTION:

(1) IS CONFIDENTIAL;

(2) DOES NOT CONSTITUTE AN ADMISSION; AND

(3) IS NOT DISCOVERABLE.

(K) UNLESS EXCUSED BY THE MEDIATOR OR NEUTRAL PROVIDER, THE PARTIES AND THE CLAIMS REPRESENTATIVE FOR EACH DEFENDANT SHALL APPEAR AT ALL CONFERENCES HELD UNDER THIS SECTION.

(L) A PARTY WHO FAILS TO COMPLY WITH THE PROVISIONS OF SUBSECTIONS (G), (J), AND (K) OF THIS SECTION IS SUBJECT TO THE PROVISIONS OF MARYLAND RULE 1-341.

(M) (1) IF A CASE IS SETTLED, THE PARTIES SHALL NOTIFY THE COURT THAT THE CASE HAS BEEN SETTLED.

(2) IF THE PARTIES AGREE TO SETTLE SOME BUT NOT ALL OF THE ISSUES IN DISPUTE, THE MEDIATOR OR NEUTRAL PROVIDER SHALL FILE A WRITTEN NOTICE OF PARTIAL SETTLEMENT WITH THE COURT.

(3) IF THE PARTIES HAVE NOT REACHED AN AGREEMENT, THE MEDIATOR OR NEUTRAL PROVIDER SHALL FILE A WRITTEN NOTICE WITH THE COURT THAT THE CASE WAS NOT SETTLED.

(N) UNLESS OTHERWISE AGREED BY THE PARTIES, THE COST OF ALTERNATIVE DISPUTE RESOLUTION SHALL BE DIVIDED EQUALLY BETWEEN THE PARTIES.

3-2A-7A.

(A) (1) AT THE CONCLUSION OF A TRIAL UNDER THIS SUBTITLE, THE COURT, ON MOTION OF A PARTY OR ON ITS OWN MOTION, MAY MAKE A FINDING AS TO WHETHER THE ACTION WAS BROUGHT OR MAINTAINED IN BAD FAITH OR WITHOUT SUBSTANTIAL JUSTIFICATION.

(2) IF THE COURT FINDS THAT THE ACTION WAS BROUGHT OR MAINTAINED IN BAD FAITH OR WITHOUT SUBSTANTIAL JUSTIFICATION, THE COURT SHALL REPORT THE FINDING AND NAME OF THE ATTORNEY OR

ATTORNEYS FOR THE CLAIMANT OR PLAINTIFF TO THE ADMINISTRATIVE OFFICE OF THE COURTS.

(B) THE ADMINISTRATIVE OFFICE OF THE COURTS SHALL:

(1) MAINTAIN A RECORD OF THE ATTORNEYS WHOSE NAMES HAVE BEEN REPORTED UNDER SUBSECTION (A) OF THIS SECTION; AND

(2) PUBLISH ON THE JUDICIARY WEBSITE A LIST CONTAINING THE NAME OF EACH ATTORNEY WHO HAS BEEN THE SUBJECT OF THREE OR MORE FINDINGS DESCRIBED IN SUBSECTION (A) OF THIS SECTION WITHIN FIVE YEARS.

(C) (1) AN ATTORNEY WHO HAS BEEN THE SUBJECT OF THREE OR MORE FINDINGS DESCRIBED IN SUBSECTION (A) OF THIS SECTION WITHIN FIVE YEARS MAY NOT BRING AN ACTION UNDER THIS SUBTITLE FOR 10 YEARS.

(2) AN ATTORNEY WHO WILFULLY VIOLATES PARAGRAPH (1) OF THIS SUBSECTION IS SUBJECT TO DISCIPLINARY PROCEEDINGS AS PROVIDED IN THE MARYLAND RULES.

(D) (1) WHEN AN ACTION IS FILED UNDER THIS SUBTITLE, THE COURT SHALL CONSULT THE LIST UNDER SUBSECTION (B)(2) OF THIS SECTION.

(2) (I) IF THE NAME OF AN ATTORNEY WHO IS THE ATTORNEY FOR THE PLAINTIFF APPEARS ON THE LIST UNDER SUBSECTION (B)(2) OF THIS SECTION, THE COURT SHALL STRIKE THE APPEARANCE OF THE ATTORNEY.

(II) WHEN THE APPEARANCE OF AN ATTORNEY IS STRICKEN UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH, AND THE PLAINTIFF HAS NO ATTORNEY OF RECORD AND HAS NOT PROVIDED WRITTEN NOTIFICATION TO PROCEED IN PROPER PERSON, IF A NEW ATTORNEY HAS NOT ENTERED AN APPEARANCE WITHIN 60 DAYS AFTER THE DATE OF THE NOTICE, THE ABSENCE OF AN ATTORNEY IS NOT GROUNDS FOR A CONTINUANCE.

(III) THE COURT SHALL SEND A NOTICE BY FIRST CLASS MAIL TO THE PLAINTIFF AT THE LAST KNOWN ADDRESS OF THE PLAINTIFF STATING THAT:

1. IF A NEW ATTORNEY HAS NOT ENTERED AN APPEARANCE WITHIN 60 DAYS AFTER THE DATE OF THE NOTICE, THE ABSENCE OF AN ATTORNEY IS NOT GROUNDS FOR A CONTINUANCE; AND

2. THE PLAINTIFF MAY RISK DISMISSAL OF THE CLAIM, JUDGMENT BY DEFAULT, AND ASSESSMENT OF COURT COSTS.

3-2A-08.

(a) (1) Evidence of advanced payments made [pursuant to] UNDER § 19-104(b) of the Insurance Article is not admissible in any arbitration or judicial proceeding for damages due to medical injury until there is an award, in the case of arbitration proceedings, or a verdict, in the case of judicial proceedings, in favor of the claimant OR PLAINTIFF and against the person who made the advanced payments.

(2) Upon the finding of such an award or verdict, the arbitration panel, or the trier of fact, shall make a finding of total damages, and shall then deduct whatever amounts it finds were paid by or on behalf of the defendants [pursuant to] UNDER § 19-104(b) of the Insurance Article.

(3) The net amount, after this deduction, shall be entered as its award or verdict.

(b) (1) If the award or verdict exceeds the amount of advanced payments and the arbitration panel or the court finds that the advanced payments were reasonable, the panel or the court may [(1) order]:

(I) ORDER that the amount by which the award or verdict exceeds the amount of advanced payments be paid over a period of time consistent with the needs of the claimant OR PLAINTIFF, rather than in a lump sum[, and (2) authorize]; AND

(II) AUTHORIZE, as part of its order, the creation of a trust or other mechanism to assure the periodic payments.

(3) The panel or court shall provide to the claimant OR PLAINTIFF the option to choose either a lump sum or payments paid over a period of time.

(c) (1) If the advanced payment exceeds the liability of the person making it, the arbitration panel or the court on appeal may order such adjustments as justice may require under the award or verdict, including, where appropriate, contribution by other parties found to be liable.

(2) In no event shall an advance payment in excess of the liability of the person making it be repayable by the person receiving it.

3-2A-08A.

(A) IN THIS SECTION "COSTS" MEANS THOSE COSTS AWARDED UNDER MARYLAND RULE 2-603.

(B) THIS SECTION DOES NOT APPLY TO CASES DISMISSED FOLLOWING A SETTLEMENT.

(C) (1) (I) AT ANY TIME NOT LESS THAN 45 DAYS BEFORE THE TRIAL BEGINS, A PARTY TO AN ACTION FOR A MEDICAL INJURY MAY SERVE ON THE ADVERSE PARTY AN OFFER OF JUDGMENT TO BE TAKEN FOR THE AMOUNT OF MONEY SPECIFIED IN THE OFFER, WITH COSTS THEN ACCRUED.

(II) WHEN THE LIABILITY OF ONE PARTY TO ANOTHER HAS BEEN DETERMINED BY VERDICT OR ORDER OR JUDGMENT, BUT THE AMOUNT OR EXTENT OF THE LIABILITY REMAINS TO BE DETERMINED BY FURTHER PROCEEDINGS, A PARTY ADJUDGED LIABLE OR A PARTY IN WHOSE FAVOR LIABILITY WAS DETERMINED MAY MAKE AN OFFER OF JUDGMENT NOT LESS THAN 45 DAYS BEFORE THE COMMENCEMENT OF HEARINGS TO DETERMINE THE AMOUNT OR EXTENT OF LIABILITY.

(D) (1) IF WITHIN 15 DAYS AFTER THE SERVICE OF THE OFFER OF JUDGMENT THE ADVERSE PARTY SERVES WRITTEN NOTICE THAT THE OFFER IS ACCEPTED, EITHER PARTY MAY THEN FILE WITH THE COURT THE OFFER AND NOTICE OF ACCEPTANCE TOGETHER WITH AN AFFIDAVIT OF SERVICE NOTIFYING THE OTHER PARTIES OF THE FILING OF THE OFFER AND ACCEPTANCE.

(2) IF THE COURT RECEIVES THE FILINGS SPECIFIED IN PARAGRAPH (1) OF THIS SUBSECTION, THE COURT SHALL ENTER JUDGMENT.

(E) (1) IF AN ADVERSE PARTY DOES NOT ACCEPT AN OFFER OF JUDGMENT WITHIN THE TIME SPECIFIED IN SUBSECTION (D)(1) OF THIS SECTION, THE OFFER SHALL BE DEEMED WITHDRAWN AND EVIDENCE OF THE OFFER IS NOT ADMISSIBLE EXCEPT IN A PROCEEDING TO DETERMINE COSTS.

(2) AN OFFER OF JUDGMENT THAT IS NOT ACCEPTED DOES NOT PRECLUDE A PARTY FROM MAKING A SUBSEQUENT OFFER OF JUDGMENT IN THE TIME SPECIFIED IN THIS SECTION.

(F) IF THE JUDGMENT FINALLY OBTAINED IS NOT MORE FAVORABLE TO THE ADVERSE PARTY THAN THE OFFER, THE ADVERSE PARTY WHO RECEIVED THE OFFER SHALL PAY THE COSTS OF THE PARTY MAKING THE OFFER INCURRED AFTER THE MAKING OF THE OFFER.

3-2A-09.

(A) THIS SECTION APPLIES TO A JUDGMENT UNDER THIS SUBTITLE FOR A CAUSE OF ACTION ARISING ON OR AFTER JANUARY 1, 2005.

(B) (1) (I) A JUDGMENT UNDER THIS SUBTITLE FOR NONECONOMIC DAMAGES MAY NOT EXCEED $650,000.

(II) THE LIMITATION ON NONECONOMIC DAMAGES PROVIDED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL INCREASE BY $15,000 ON OCTOBER 1 OF EACH YEAR BEGINNING ON JANUARY 1, 2008. THE INCREASED AMOUNT SHALL APPLY TO CAUSES OF ACTION ARISING BETWEEN JANUARY 1 OF THAT YEAR AND DECEMBER 31 OF THE FOLLOWING YEAR, INCLUSIVE.

(2) THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL APPLY IN THE AGGREGATE TO ALL CLAIMS FOR PERSONAL INJURY AND WRONGFUL DEATH ARISING FROM THE SAME MEDICAL INJURY, REGARDLESS OF THE NUMBER OF CLAIMS, PLAINTIFFS, OR DEFENDANTS.

(3) (I) IN A JURY TRIAL, THE JURY MAY NOT BE INFORMED OF THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(II) IF THE JURY AWARDS AN AMOUNT FOR NONECONOMIC DAMAGES THAT EXCEEDS THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COURT SHALL REDUCE THE AMOUNT TO CONFORM TO THE LIMITATION.

(III) IN A WRONGFUL DEATH ACTION IN WHICH THERE ARE TWO OR MORE CLAIMANTS OR BENEFICIARIES, IF THE JURY AWARDS AN AMOUNT FOR NONECONOMIC DAMAGES THAT EXCEEDS THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION OR A REDUCTION UNDER SUBPARAGRAPH (IV) OF THIS PARAGRAPH, THE COURT SHALL:

1. IF THE AMOUNT OF NONECONOMIC DAMAGES FOR THE PRIMARY CLAIMANTS, AS DESCRIBED UNDER § 3-904(D) OF THIS TITLE, EQUALS OR EXCEEDS THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION OR A REDUCTION UNDER SUBPARAGRAPH (IV) OF THIS PARAGRAPH:

A. REDUCE EACH INDIVIDUAL AWARD OF A PRIMARY CLAIMANT PROPORTIONATELY TO THE TOTAL AWARD OF ALL PRIMARY

CLAIMANTS SO THAT THE TOTAL AWARD TO ALL CLAIMANTS OR BENEFICIARIES CONFORMS TO THE LIMITATION OR REDUCTION; AND

B. REDUCE EACH AWARD, IF ANY, TO A SECONDARY CLAIMANT, AS DESCRIBED UNDER § 3-904(B) OF THIS TITLE TO ZERO DOLLARS; OR

2. IF THE AMOUNT OF NONECONOMIC DAMAGES FOR THE PRIMARY CLAIMANTS DOES NOT EXCEED THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION OR A REDUCTION UNDER SUBPARAGRAPH (IV) OF THIS PARAGRAPH OR IF THERE IS NO AWARD TO A PRIMARY CLAIMANT:

A. ENTER AN AWARD TO EACH PRIMARY CLAIMANT, IF ANY, AS DIRECTED BY THE VERDICT; AND

B. REDUCE EACH INDIVIDUAL AWARD OF A SECONDARY CLAIMANT PROPORTIONATELY TO THE TOTAL AWARD OF ALL OF THE SECONDARY CLAIMANTS SO THAT THE TOTAL AWARD TO ALL CLAIMANTS OR BENEFICIARIES CONFORMS TO THE LIMITATION OR REDUCTION.

(IV) IN A CASE IN WHICH THERE IS A PERSONAL INJURY ACTION AND A WRONGFUL DEATH ACTION, IF THE TOTAL AMOUNT AWARDED BY THE JURY FOR NONECONOMIC DAMAGES FOR BOTH ACTIONS EXCEEDS THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COURT SHALL REDUCE THE AWARD IN EACH ACTION PROPORTIONATELY SO THAT THE TOTAL AWARD FOR NONECONOMIC DAMAGES FOR BOTH ACTIONS CONFORMS TO THE LIMITATION.

(C) (1) A VERDICT FOR PAST MEDICAL EXPENSES SHALL BE LIMITED TO:

(I) THE TOTAL AMOUNT OF PAST MEDICAL EXPENSES PAID BY OR ON BEHALF OF THE PLAINTIFF; AND

(II) THE TOTAL AMOUNT OF PAST MEDICAL EXPENSES INCURRED BUT NOT PAID BY OR ON BEHALF OF THE PLAINTIFF FOR WHICH THE PLAINTIFF OR ANOTHER PERSON ON BEHALF OF THE PLAINTIFF IS OBLIGATED TO PAY.

(2) THE VERDICT FOR PAST OR FUTURE LOSS OF EARNINGS SHALL EXCLUDE ANY AMOUNT FOR FEDERAL, STATE, OR LOCAL INCOME TAXES OR PAYROLL TAXES, INCLUDING SOCIAL SECURITY AND MEDICARE, THAT THE PLAINTIFF WOULD HAVE PAID ON THESE EARNINGS, DETERMINED AT THE TAX

RATES IN EFFECT FOR THE PLAINTIFF AT THE TIME THE AWARD OR VERDICT IS ENTERED.

(3) (I) EXCEPT AS OTHERWISE PROVIDED IN THIS PARAGRAPH, THERE IS A REBUTTABLE PRESUMPTION THAT A VERDICT FOR FUTURE MEDICAL EXPENSES SHALL BE BASED SOLELY ON MEDICARE REIMBURSEMENT RATES IN EFFECT ON THE DATE OF THE AWARD OR VERDICT FOR THE LOCALITY IN WHICH THE CARE IS TO BE PROVIDED, ADJUSTED FOR INFLATION AS PROVIDED IN SUBPARAGRAPH (V) OF THIS PARAGRAPH.

(II) IF ON THE DATE OF THE AWARD OR VERDICT, THE MEDICARE WAIVER UNDER § 1814(B) OF THE FEDERAL SOCIAL SECURITY ACT IS IN EFFECT, A VERDICT FOR FUTURE MEDICAL EXPENSES FOR HOSPITAL FACILITY SERVICES SHALL BE BASED SOLELY ON THE RATES APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION IN EFFECT ON THE DATE OF THE AWARD OR VERDICT FOR THE HOSPITAL FACILITY IN WHICH SERVICES ARE TO BE PROVIDED, ADJUSTED FOR INFLATION AS PROVIDE D IN THE ANNUAL RATE UPDATES APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION.

(III) A VERDICT FOR FUTURE MEDICAL EXPENSES FOR NURSING FACILITY SERVICES SHALL BE BASED SOLELY ON THE STATEWIDE AVERAGE PAYMENT RATE FOR THE MEDICAL ASSISTANCE PROGRAM DETERMINED BY THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE IN EFFECT ON THE DATE OF THE AWARD OR VERDICT, ADJUSTED FOR INFLATION AS PROVIDED IN SUBPARAGRAPH (V) OF THIS PARAGRAPH.

(IV) A VERDICT FOR FUTURE ECONOMIC DAMAGES FOR WHICH THERE IS NO MEDICARE REIMBURSEMENT RATE, HOSPITAL FACILITY RATE, OR STATEWIDE AVERAGE PAYMENT SHALL BE BASED ON ACTUAL COST ON THE DATE OF THE AWARD OR VERDICT, ADJUSTED FOR INFLATION AS PROVIDED IN SUBPARAGRAPH (V) OF THIS PARAGRAPH.

(V) 1. FUTURE ECONOMIC DAMAGES SHALL BE ADJUSTED FOR INFLATION FOR THE EXPENDITURE CATEGORY OF THE CONSUMER PRICE INDEX PUBLISHED BY THE BUREAU OF LABOR STATISTICS TO WHICH THE EXPENSE APPLIES.

2. THE ADJUSTMENT FOR INFLATION IN THIS PARAGRAPH SHALL BE BASED ON THE AVERAGE RATE OF INFLATION FOR THE 5 YEARS IMMEDIATELY PRECEDING THE AWARD OR VERDICT.

[3-2A-09.] 3-2A-11.

[The] EXCEPT FOR §§ 3-2A-02, 3-2A-06, AND 3-2A-09, THE provisions of this subtitle shall be deemed procedural in nature and [shall] MAY not be construed to create, enlarge, or diminish any cause of action not heretofore existing, except the defense of failure to comply with the procedures required under this subtitle.

11-108.

(c) An award by the health claims arbitration panel in accordance with [§ 3-2A-06] § 3-2A-05 of this article FOR DAMAGES IN WHICH THE CAUSE OF ACTION AROSE BEFORE JANUARY 1, 2005, shall be considered an award for purposes of this section.

(E) THE PROVISIONS OF THIS SECTION DO NOT APPLY TO A JUDGMENT UNDER TITLE 3, SUBTITLE 2A OF THIS ARTICLE FOR DAMAGES IN WHICH THE CAUSE OF ACTION ARISES ON OR AFTER JANUARY 1, 2005.

11-109.

(c) (1) The court [or the health claims arbitration panel] may order that all or part of the future economic damages portion of the award be paid in the form of annuities or other appropriate financial instruments, or that it be paid in periodic or other payments consistent with the needs of the plaintiff, funded in full by the defendant or the defendant's insurer and equal when paid to the amount of the future economic damages award.

(2) In the event that the court [or panel] shall order that the award for future economic damages be paid in a form other than a lump sum, the court [or panel] shall order that the defendant or the defendant's insurer provide adequate security for the payment of all future economic damages.

(3) The court [or panel] may appoint a conservator under this subsection for the plaintiff, upon such terms as the court [or panel] may impose, who shall have the full and final authority to resolve any dispute between the plaintiff and the defendant or the defendant's insurer regarding the need or cost of expenses for the plaintiff's medical, surgical, custodial, or other care or treatment.
[(d)] (4) If the plaintiff [under this section] dies before the final periodic payment of an award is made, the unpaid balance of the award for future loss of earnings shall revert to the estate of the plaintiff and the unpaid balance of the award for future medical expenses shall revert to the defendant or to the defendant's insurer if the insurer provided the funds for the future damages award.

(D) IF A HEALTH CLAIMS ARBITRATION PANEL AWARDS FUTURE ECONOMIC DAMAGES IN ACCORDANCE WITH § 3-2A-05 OF THIS ARTICLE THE ARBITRATION PANEL MAY ORDER THAT FUTURE ECONOMIC DAMAGES BE PAID IN ACCORDANCE

WITH THE PROVISIONS OF SUBSECTION (C) OF THIS SECTION.

Article - Health General

19-319.

(I) (1) IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE DEPARTMENT, A HOSPITAL SHALL REPORT AN UNEXPECTED OCCURRENCE RESULTING IN DEATH OR SERIOUS DISABILITY RELATED TO AN INDIVIDUAL'S MEDICAL TREATMENT AND NOT RELATED TO THE NATURAL COURSE OF THE PATIENT'S ILLNESS OR UNDERLYING DISEASE CONDITION.

(2) IF A HOSPITAL FAILS TO COMPLY WITH PARAGRAPH (1) OF THIS SUBSECTION, THE SECRETARY MAY IMPOSE:

(I) FOR A FIRST OFFENSE, A CIVIL PENALTY NOT EXCEEDING $5,000 FOR EACH VIOLATION; OR

(II) FOR A SECOND OR SUBSEQUENT OFFENSE WITHIN THREE YEARS, A CIVIL PENALTY OF NOT LESS THAN $1,000 AND NOT MORE THAN $15,000.

(3) THE SECRETARY SHALL PRESCRIBE FORMS FOR HOSPITALS TO USE WHEN REPORTING ADVERSE EVENTS.

Article - Health Occupations

1-401.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Alternative health care system" means a system of health care delivery other than a hospital or related institution.

(ii) "Alternative health care system" includes:

1. A health maintenance organization;

2. A preferred provider organization;

3. An independent practice association;

4. A community health center that is a nonprofit, freestanding ambulatory health care provider governed by a voluntary board of directors and that provides primary health care services to the medically indigent;

5. A freestanding ambulatory care facility as that term is defined in § 19-3B-01 of the Health - General Article; or

6. Any other health care delivery system that utilizes a medical review committee.

(3) "Medical review committee" means a committee or board that:

(i) Is within one of the categories described in subsection (b) of this section; and

(ii) Performs functions that include at least one of the functions listed in subsection (c) of this section.

(4) (i) "Provider of health care" means any person who is licensed by law to provide health care to individuals.

(ii) "Provider of health care" does not include any nursing institution that is conducted by and for those who rely on treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination.

(5) "The Maryland Institute for Emergency Medical Services Systems" means the State agency described in § 13-503 of the Education Article.

(b) For purposes of this section, a medical review committee is:

(1) A regulatory board or agency established by State or federal law to license, certify, or discipline any provider of health care;

(2) A committee of the Faculty or any of its component societies or a committee of any other professional society or association composed of providers of health care;

(3) A committee appointed by or established in a local health department for review

purposes;

(4) A committee appointed by or established in the Maryland Institute for Emergency Medical Services Systems;

(5) A committee of the medical staff or other committee, including any risk management, credentialing, or utilization review committee established in accordance with § 19-319 of the Health - General Article, of a hospital, related institution, or alternative health care system, if the governing board of the hospital, related institution, or alternative health care system forms and approves the committee or approves the written bylaws under which the committee operates;

(6) A committee or individual designated by the holder of a pharmacy permit, as defined in § 12-101 of this article, that performs the functions listed in subsection (c) of this section, as part of a pharmacy's ongoing quality assurance program;

(7) Any person, including a professional standard review organization, who contracts with an agency of this State or of the federal government to perform any of the functions listed in subsection (c) of this section;

(8) Any person who contracts with a provider of health care to perform any of those functions listed in subsection (c) of this section that are limited to the review of services provided by the provider of health care;

(9) An organization, established by the Maryland Hospital Association, Inc. and the Faculty, that contracts with a hospital, related institution, or alternative delivery system to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a hospital in meeting the requirements of § 19-319(e) of the Health - General Article;

(10) A committee appointed by or established in an accredited health occupations school;

(11) An organization described under § 14-501 of this article that contracts with a hospital, related institution, or health maintenance organization to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a health maintenance organization in meeting the requirements of Title 19, Subtitle 7 of the Health - General Article, the National Committee for Quality Assurance (NCQA),

or any other applicable credentialing law or regulation;

(12) An accrediting organization as defined in § 14-501 of this article;

(13) A Mortality Review Committee established under § 5-801 of the Health - General Article; or

(14) A center designated by the Maryland Health Care Commission as the Maryland Patient Safety Center that performs the functions listed in subsection (c)(1) of this section.

(c) For purposes of this section, a medical review committee:

(1) Evaluates and seeks to improve the quality of health care provided by providers of health care;

(2) Evaluates the need for and the level of performance of health care provided by providers of health care;

(3) Evaluates the qualifications, competence, and performance of providers of health care; or

(4) Evaluates and acts on matters that relate to the discipline of any provider of health care.

(d) (1) Except as otherwise provided in this section, the proceedings, records, and files of a medical review committee are not discoverable and are not admissible in evidence in any civil action.

(2) The proceedings, records, and files of a medical review committee are confidential and are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee if requested by the following:

(i) The Department of Health and Mental Hygiene to ensure compliance with the provisions of § 19-319 of the Health - General Article;

(ii) A health maintenance organization to ensure compliance with the provisions of Title 19, Subtitle 7 of the Health - General Article and applicable regulations;

(iii) A health maintenance organization to ensure compliance with the National Committee for Quality Assurance (NCQA) credentialing requirements; or

(iv) An accrediting organization to ensure compliance with accreditation requirements or the procedures and policies of the accrediting organization.

(3) If the proceedings, records, and files of a medical review committee are requested by any person from any of the entities in paragraph (2) of this subsection:

(i) The person shall give the medical review committee notice by certified mail of the nature of the request and the medical review committee shall be granted a protective order preventing the release of its proceedings, records, and files; and

(ii) The entities listed in paragraph (2) of this subsection may not release any of the proceedings, records, and files of the medical review committee.

(e) Subsection (d)(1) of this section does not apply to:

(1) A civil action brought by a party to the proceedings of the medical review committee who claims to be aggrieved by the decision of the medical review committee; or

(2) Any record or document that is considered by the medical review committee and that otherwise would be subject to discovery and introduction into evidence in a civil trial.

(f) (1) A person shall have the immunity from liability described under § 5-637 of the Courts and Judicial Proceedings Article for any action as a member of the medical review committee or for giving information to, participating in, or contributing to the function of the medical review committee.

(2) A contribution to the function of a medical review committee includes any statement by any person, regardless of whether it is a direct communication with the medical review committee, that is made within the context of the person's employment or is made to a person with a professional interest in the functions of a medical review committee and is intended to lead to redress of a matter within the scope of a medical review committee's functions.

(G) IN A CIVIL ACTION BROUGHT BY A PARTY TO THE PROCEEDINGS OF A MEDICAL REVIEW COMMITTEE DESCRIBED IN SUBSECTION (B)(5), (9), OR (11) OF THIS SECTION WHO CLAIMS TO BE AGGRIEVED BY THE DECISION OF THE MEDICAL REVIEW COMMITTEE, THE COURT SHALL AWARD COURT COSTS AND REASONABLE ATTORNEY'S FEES TO THE PREVAILING PARTY, INCLUDING A PERSON DESCRIBED IN SUBSECTION (F) OF THIS SECTION IF THE PERSON IS A PREVAILING PARTY IN THE CIVIL ACTION.

[(g)] (H) Notwithstanding this section, §§ 14-410 and 14-412 of this article apply to:

(1) The Board of Physicians; and

(2) Any other entity, to the extent that it is acting in an investigatory capacity for the Board of Physicians.

14-101.

(l) (1) "Practice medicine" means to engage, with or without compensation[, in medical]:

(i) IN MEDICAL:

1. Diagnosis;

[(ii)] 2. Healing;

[(iii)] 3. Treatment; or

[(iv)] 4. Surgery; OR

(II) IN TESTIFYING AS OR OFFERING AN OPINION AS A MEDICAL EXPERT WITNESS REGARDING THE CONDUCT DESCRIBED IN ITEM (I) OF THIS PARAGRAPH IN THE COURSE OF A LEGAL PROCEEDING.

14-302.

Subject to the rules, regulations, and orders of the Board, the following individuals may practice medicine without a license:

(1) A medical student or an individual in a postgraduate medical training program that is approved by the Board, while doing the assigned duties at any office of a licensed physician, hospital, clinic, or similar facility;

(2) A physician licensed by and residing in another jurisdiction, while engaging in consultation with a physician licensed in this State;

(3) A physician employed in the service of the federal government while performing the duties incident to that employment;

(4) A physician who resides in and is authorized to practice medicine by any state adjoining this State and whose practice extends into this State, if:

(i) The physician does not have an office or other regularly appointed place in this State to meet patients; and

(ii) The same privileges are extended to licensed physicians of this State by the adjoining state; [and]

(5) An individual while under the supervision of a licensed physician who has specialty training in psychiatry, and whose specialty training in psychiatry has been approved by the Board, if the individual submits an application to the Board on or before October 1, 1993, and either:

(i) 1. Has a master's degree from an accredited college or university; and

2. Has completed a graduate program accepted by the Board in a behavioral science that includes 1,000 hours of supervised clinical psychotherapy experience; or

(ii) 1. Has a baccalaureate degree from an accredited college or university; and

2. Has 4,000 hours of supervised clinical experience that is approved by the Board; AND

(6) A PHYSICIAN LICENSED BY AND RESIDING IN ANOTHER JURISDICTION, WHILE TESTIFYING IN A CIVIL ACTION OR ATTESTING TO COMPLIANCE WITH OR DEPARTURES FROM STANDARDS OF CARE FOR PURPOSES OF A CERTIFICATE OF QUALIFIED EXPERT UNDER TITLE 3, SUBTITLE 2A OF THE COURTS ARTICLE.

14-401.

(i) Those individuals not licensed under this title but covered under § 14-302(6) OF THIS TITLE OR § 14-413(a)(1)(ii)3 and 4 of this subtitle are subject to the hearing provisions of § 14-405 of this subtitle.

14-404.1.

SUBJECT TO THE HEARING PROVISIONS OF § 14-405 OF THIS SUBTITLE AND APPROPRIATE PEER REVIEW, THE BOARD, ON THE AFFIRMATIVE VOTE OF A MAJORITY OF THE QUORUM, MAY ISSUE FINDINGS AND A REPORT CONCERNING AN INDIVIDUAL COVERED UNDER § 14-302(6) OF THIS TITLE WHO FALSELY TESTIFIES OR FALSELY OFFERS AN OPINION AS A MEDICAL EXPERT WITNESS REGARDING MEDICAL DIAGNOSIS, HEALING, TREATMENT, OR SURGERY.

14-405.

(a) Except as otherwise provided in the Administrative Procedure Act, before the Board takes any action under § 14-404(a) OR § 14-404.1 of this subtitle or § 14-5A-17(a) of this title, it shall give the individual against whom the action is contemplated an opportunity for a hearing before a hearing officer.

(b) (1) The hearing officer shall give notice and hold the hearing in accordance with the Administrative Procedure Act.

(2) [Except as provided in paragraph (3) of this subsection, factual] FACTUAL findings shall be supported by a preponderance of the evidence.

[(3) Factual findings shall be supported by clear and convincing evidence if the charge of the Board is based on § 14-404(a)(22), § 14-5A-17(a)(18), or § 14-5B-14(a)(18) of this title.]

(c) The individual may be represented at the hearing by counsel.

(d) If after due notice the individual against whom the action is contemplated fails or refuses to appear, nevertheless the hearing officer may hear and refer the matter to the Board for disposition.

(e) After performing any necessary hearing under this section, the hearing officer shall refer proposed factual findings to the Board for the Board's disposition.

(f) The Board may adopt regulations to govern the taking of depositions and discovery in the hearing of charges.

(g) The hearing of charges may not be stayed or challenged by any procedural defects alleged to have occurred prior to the filing of charges.

Article - Insurance

2-213.

(A) IN THIS SECTION, "PEOPLE'S COUNSEL" MEANS THE PEOPLE'S INSURANCE COUNSEL ESTABLISHED UNDER TITLE 6, SUBTITLE 3 OF THE STATE GOVERNMENT ARTICLE.

[(a)](B)(1) Except as otherwise provided in this subsection, all hearings shall be open to the public in accordance with Article 41, § 1-205 of the Code.

(2) A hearing held by the Commissioner that relates to a filing under Title 11 of this article is not required to be open to the public.

(3) A hearing held by the Commissioner to determine whether an insurer is being operated in a hazardous manner that could result in its impairment is not required to be open to the public if:

(i) the insurer requests that the hearing not be a public hearing; and

(ii) the Commissioner determines that it is not in the interest of the public to hold a public hearing.

(4) A hearing held by the Commissioner to evaluate the financial condition of an insurer under the risk based capital standards set out in Title 4, Subtitle 3 of this article is not required to be open to the public.

[(b)] (C) (1) The Commissioner shall allow any party to a hearing to:

(i) appear in person;

(ii) be represented:

1. by counsel; or

2. in the case of an insurer, by a designee of the insurer who:

A. is employed by the insurer in claims, underwriting, or as otherwise provided by the Commissioner; and

B. has been given the authority by the insurer to resolve all issues involved in the hearing;

(iii) be present while evidence is given;

(iv) have a reasonable opportunity to inspect all documentary evidence and to examine witnesses; and

(v) present evidence.

(2) On request of a party, the Commissioner shall issue subpoenas to compel attendance of witnesses or production of evidence on behalf of the party.

[(c)] (D) The Commissioner shall allow any person that was not an original party to a hearing to

become a party by intervention if:

(1) the intervention is timely; and

(2) the financial interests of the person will be directly and immediately affected by an order of the Commissioner resulting from the hearing.

[(d)](E) (1) Formal rules of pleading or evidence need not be observed at a hearing.

(2) IN A HEARING ON A MEDICAL PROFESSIONAL LIABILITY INSURER'S RATE FILING IN WHICH PEOPLE'S COUNSEL APPEARS, THE RIGHT TO CROSS EXAMINE WITNESSES MAY BE EXERCISED BY:

(I) THE PEOPLE'S COUNSEL; AND

(II) THE MEDICAL PROFESSIONAL LIABILITY INSURER WHOSE RATE FILING IS THE SUBJECT OF THE HEARING.

[(e)] (F) (1) On timely written request by a party to a hearing, the Commissioner shall have a full stenographic record of the proceedings made by a competent reporter at the expense of that party.

(2) If the stenographic record is transcribed, a copy shall be given on request to any other party to the hearing at the expense of that party.

(3) If the stenographic record is not made or transcribed, the Commissioner shall prepare an adequate record of the evidence and proceedings.

4-401.

(a) This section applies to:

(1) each insurer that provides professional liability insurance to:

(i) a physician, nurse, dentist, podiatrist, optometrist, or chiropractor licensed under the Health Occupations Article; or

(ii) a hospital licensed under the Health - General Article; and

(2) each self-insured hospital.

(b) An entity subject to this section shall report quarterly any claim or action for damages for personal injury if the claim or action:

(1) is claimed to have been caused by an error, omission, or negligence in the performance of the insured's professional services or is based on a claimed performance of the insured's professional services without consent; and

(2) resulted in:

(i) a final judgment in any amount;

(ii) a settlement in any amount; or

(iii) a final disposition that does not result in payment on behalf of the insured.

(c) A report required under this section shall contain:

(1) the name and address of the insured;

(2) the policy number of the insured;

(3) the date of the occurrence from which the claim or action arose;

(4) the JURISDICTION AND date of filing suit, if any;

(5) the date and amount of final judgment or settlement, if any;

(6) THE SPECIFIC AMOUNT OF THE FINAL JUDGMENT OR SETTLEMENT, IF ANY, THAT IS FOR:

(I) PAST MEDICAL EXPENSES;

(II) FUTURE MEDICAL EXPENSES;

(III) PAST LOST WAGES;

(IV) FUTURE LOST WAGES;

(V) ECONOMIC DAMAGES; AND

(VI) NON-ECONOMIC DAMAGES;

[(6)] (7) THE SPECIFIC AMOUNT OF DAMAGES CLAIMED BY THE PLAINTIFF(S) THAT WAS FOR:

(I) PAST MEDICAL EXPENSES;

(II) FUTURE MEDICAL EXPENSES;

(III) PAST LOST WAGES;

(IV) FUTURE LOST WAGES;

(V) ECONOMIC DAMAGES; AND

(VI) NON-ECONOMIC DAMAGES;

[(7)] (8) if there is no final judgment or settlement, the date and reason for final disposition;

[(8)] (9) a summary of the occurrence from which the claim or action arose;

[(9)] (10) WHETHER THERE WAS A CLAIM MADE FOR EXTRACONTRACTUAL DAMAGES AND IF SO THE MEDICAL PROFESSIONAL LIABILITY INSURER WHOSE RATE FILING IS THE SUBJECT OF THE HEARING.

(d) A report required under this section shall be filed within 90 days after the end of the quarter during which an event described in subsection (b)(2)(i), (ii), or (iii) of this section occurred.

(e) (1) A report that relates to a physician shall be filed with the State Board of Physicians.

(2) A report that relates to a hospital shall be filed with the Secretary of Health and Mental Hygiene.

(3) A report that relates to a nurse, dentist, podiatrist, optometrist, or chiropractor shall be filed with the appropriate licensing board for these health care providers.

(4) A REPORT FILED UNDER THIS SUBSECTION SHALL ALSO BE FILED WITH THE COMMISSIONER.

(f) (1) Subject to paragraph (2) of this subsection, a report filed in accordance with this section shall be treated as a personal record under § 10-624(e) of the State Government Article.

(2) Each report shall be released to the Maryland Health Care Commission.

(g) An insurer that reports under this section or its agents or employees, the State Board of Physicians or its representatives, and any appropriate licensing authority that receives a report under this section shall have the immunity from liability described in §§ 5-701 of the Courts Article for any action taken by them under this section.

(h) (1) NOTWITHSTANDING THE PROVISIONS IN PARAGRAPH (2) OF THIS SUBSECTION, THE
COMMISSIONER MAY IMPOSE A CIVIL PENALTY NOT EXCEEDING $5,000 ON A PERSON WHO FAILS TO REPORT TO THE COMMISSIONER IN ACCORDANCE WITH THIS SECTION

(2) Failure to report in accordance with this section shall result in the imposition by a circuit court of a civil penalty of up to $5,000.

4-401.1.

(A)(1)AN INSURER DESCRIBED IN § 4-401 OF THIS SUBTITLE SHALL SUBMIT ANNUALLY TO THE COMMISSIONER INFORMATION ON:

(I) THE NATURE AND COST OF REINSURANCE;

(II) THE CLAIMS EXPERIENCE BY CATEGORY OF HEALTH CARE PROVIDERS;

(III) THE AMOUNT OF CLAIMS SETTLEMENTS AND CLAIMS AWARDS;

(IV) THE NUMBER OF CASES THAT WERE TRIED AND INFORMATION ON THE VERDICTS, INCLUDING REDUCTIONS IN THE VERDICTS REQUIRED OR PERMITTED UNDER LAW;

(V) THE NUMBER OF HEALTH CARE PROVIDERS INSURED;

(VI) INFORMATION RELATING TO THE SURPLUS OF THE INSURER AS REQUIRED BY THE COMMISSIONER;

(VII) THE NUMBER OF CLAIMS MADE, THE NUMBER OF CLAIMS PAID, AND THE TOTAL AMOUNT OF MONEY PAID FOR CLAIMS;

(VIII) INFORMATION RELATING TO THE AMOUNT OF RESERVES OF THE INSURER, INCLUDING RESERVES FOR CLAIMS INCURRED AND INCURRED BUT UNREPORTED CLAIMS;

(IX) THE NUMBER OF STRUCTURED SETTLEMENTS USED IN PAYMENT OF CLAIMS; AND

(X) ANY OTHER INFORMATION RELATING TO HEALTH CARE MALPRACTICE CLAIMS AS PRESCRIBED BY THE COMMISSIONER IN REGULATIONS.

(2) THE COMMISSIONER MAY ADOPT REGULATIONS ON THE SUBMISSION OF INFORMATION UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(B) THE COMMISSIONER MAY REQUIRE BY REGULATION INSURERS OF OTHER LINES OF LIABILITY INSURANCE TO SUBMIT REPORTS.

(C) THE COMMISSIONER SHALL REPORT, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE COMMISSIONER'S FINDINGS AS TO THE IMPACT OF THIS ACT ON THE AVAILABILITY OF HEALTH CARE MALPRACTICE AND OTHER LIABILITY INSURANCE IN THE STATE TO THE GOVERNOR AND THE GENERAL ASSEMBLY ON OR BEFORE SEPTEMBER 1 OF EACH YEAR.

Article - State Government

SUBTITLE 3. PEOPLE'S INSURANCE COUNSEL.

6-301.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "COMMISSIONER" MEANS THE MARYLAND INSURANCE COMMISSIONER.

(C) "MEDICAL PROFESSIONAL LIABILITY INSURER" MEANS AN INSURER THAT:

(1) HOLDS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER; AND

(2) ISSUES OR DELIVERS POLICIES OF MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THE STATE.

(D) "PREMIUM" HAS THE MEANING STATED IN § 1-101 OF THE INSURANCE ARTICLE TO THE EXTENT IT IS ALLOCATED TO THIS STATE.

6-302.

(A) (1) THERE IS A PEOPLE'S INSURANCE COUNSEL IN THE OFFICE OF ATTORNEY GENERAL.

(2) THE PEOPLE'S INSURANCE COUNSEL SHALL BE AN ASSISTANT ATTORNEY GENERAL AND SHALL BE APPOINTED BY THE ATTORNEY GENERAL.

(B) THE PEOPLE'S INSURANCE COUNSEL:

(1) SHALL BE ADMITTED TO PRACTICE LAW IN THE STATE;

(2) SHALL HAVE KNOWLEDGE AND EXPERTISE IN THE BUSINESS OF INSURANCE; AND

(3) MAY NOT BE FINANCIALLY INTERESTED IN AN INSURER, INSURANCE AGENCY, OR INSURANCE TRANSACTION, OTHER THAN AS A POLICY HOLDER OR CLAIMANT UNDER A POLICY.

6-303.

(A) THE OFFICE OF ATTORNEY GENERAL SHALL INCLUDE IN ITS ANNUAL BUDGET SUFFICIENT MONEY TO PERFORM THE DUTIES OF THE PEOPLE'S INSURANCE COUNSEL SET FORTH UNDER THIS SUBTITLE.

(B) THE PEOPLE'S INSURANCE COUNSEL MAY RETAIN AS NECESSARY FOR A PARTICULAR MATTER EXPERTS IN THE FIELD OF INSURANCE RATE MAKING, INCLUDING ACCOUNTANTS AND ACTUARIES.

6-304.

(A) THE COMMISSIONER SHALL:

(1) COLLECT AN ANNUAL ASSESSMENT FROM EACH MEDICAL PROFESSIONAL LIABILITY INSURER FOR THE COSTS AND EXPENSES INCURRED BY THE OFFICE OF ATTORNEY GENERAL IN CARRYING OUT THE DUTIES SET FORTH UNDER THIS SUBTITLE; AND

(2) PAY THE AMOUNTS COLLECTED TO THE OFFICE OF ATTORNEY GENERAL TO BE USED ONLY FOR THE EXPENSES OF THE PEOPLE'S INSURANCE COUNSEL.

(B) THE ASSESSMENT IS THE PRODUCT OF THE FRACTION OBTAINED BY

DIVIDING THE GROSS DIRECT PREMIUM WRITTEN BY THE MEDICAL PROFESSIONAL LIABILITY INSURER IN THE PRIOR CALENDAR YEAR BY THE TOTAL AMOUNT OF GROSS DIRECT PREMIUM WRITTEN BY ALL MEDICAL PROFESSIONAL LIABILITY INSURERS IN THE PRIOR CALENDAR YEAR, MULTIPLIED BY THE AMOUNT OF THE TOTAL COSTS AND EXPENSES UNDER SUBSECTION (A)(1) OF THIS SECTION.

6-305.

(A) (1) THE PEOPLE'S INSURANCE COUNSEL SHALL REVIEW AND INVESTIGATE ANY PROPOSED RATE INCREASE OF 10% OR MORE FILED WITH THE COMMISSIONER BY A MEDICAL PROFESSIONAL LIABILITY INSURER.

(2) IF THE PEOPLE'S INSURANCE COUNSEL FINDS THAT THE PROPOSED RATE INCREASE IS EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY, THE PEOPLE'S INSURANCE COUNSEL SHALL:

(I) REQUEST A HEARING BEFORE THE COMMISSIONER ON THE RATE FILING; AND

(II) APPEAR AT THE RATE FILING TO:

1. PRESENT EVIDENCE, INCLUDING THE REPORT AND TESTIMONY OF AN ACCREDITED ACTUARY, THAT THE PROPOSED RATE IS EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY;

2. IDENTIFY AN ALTERNATIVE RATE; AND

3. PRESENT EVIDENCE, INCLUDING THE REPORT AND TESTIMONY OF AN ACCREDITED ACTUARY, THAT THE ALTERNATIVE RATE IS NOT EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY.

(3) FOR ALL PURPOSES RELATED TO THE RATE FILINGS OF MEDICAL PROFESSIONAL LIABILITY INSURERS, THE PEOPLE'S INSURANCE COUNSEL SHALL BE CONSIDERED TO BE A PERSON AGGRIEVED BY THE FILING.

19-104.

(a) Each policy that insures a health care provider against damages due to medical injury arising from providing or failing to provide health care shall contain provisions that:

(1) are consistent with the requirements of Title 3, Subtitle 2A of the Courts Article; and

(2) authorize the insurer, without restriction, to negotiate and effect a compromise of claims within the limits of the insurer's liability, if the entire amount settled on is to be paid by the insurer.

(b) (1) An insurer may make payments to or on behalf of claimants for reasonable hospital and medical costs,
loss of wages, and expenses for rehabilitation services and treatment, within the limits of the insurer's liability, before a final disposition of the claim.

(2) A payment made under this subsection:

(i) is not an admission of liability to or of damages sustained by a claimant; and

(ii does not prejudice the insurer or any other party with respect to any right, claim, or defense.

(C) (1) A POLICY ISSUED OR DELIVERED UNDER SUBSECTION (A) OF THIS SECTION MAY NOT INCLUDE COVERAGE FOR THE DEFENSE OF A HEAL m CARE PROVIDER IN A DISCIPLINARY HEARING ARISING OUT OF THE PRACTICE OF THE HEALTH CARE PROVIDER'S PROFESSION.

(2) A POLICY PROVIDING COVERAGE FOR THE DEFENSE OF A HEAL m CARE PROVIDER IN DISCIPLINARY HEARING ARISING OUT OF THE PRACTICE OF THE HEALTH CARE PROVIDER'S PROFESSION MAY BE OFFERED AND PRICED SEPARATELY FROM A POLICY ISSUED OR DELIVERED UNDER SUBSECTION (A) OF THIS

Article - Insurance

24-209.

(C) THE SOCIETY MAY NOT DENY MEDICAL LIABILITY INSURANCE COVERAGE TO ANY PHYSICIAN BASED SOLELY UPON THEIR MEDICAL SPECIALTY, PRACTICE PROFILE, OR GEOGRAPHIC LOCATION OF PRACTICE.

SECTION 2. AND BE IT FURTHER ENACTED, That the laws of Maryland read as follows:

Article - Courts and Judicial Proceedings

3-2A-08.

(a) (1) Evidence of advanced payments made under § 19-1 04(b) of the

Insurance Article is not admissible in any [arbitration or] judicial proceeding for damages due to medical injury until there is [an award, in the case of arbitration proceedings, or] a verdict[, in the case of judicial proceedings,] in favor of the [claimant or] plaintiff and against the person who made the advanced payments.

(2) Upon the finding of such [an award or] A verdict, [the arbitration panel, or] the trier of fact[,] shall make a finding of total damages, and shall then deduct whatever amounts it finds were paid by or on behalf of the defendants under § 19-1 04(b) of the Insurance Article.

(3) The net amount, after this deduction, shall be entered as its [award or] verdict.

(b) (1) The provisions of this subsection do not apply to a verdict for damages under this subtitle in which the cause of action arises on or after January 1, 2005.

(2) For [an award or] A verdict for damages under this subtitle in which the cause of action arose before January 1, 2005, if the [award or] verdict exceeds the amount of advanced payments and the arbitration panel or the court finds that the advanced payments were reasonable, the [panel or the] court may:

(i) Order that the amount by which the [award or] verdict exceeds the amount of advanced payments be paid over a period of time consistent with the needs of the [claimant or] plaintiff, rather than in a lump sum; and

(ii) the periodic payments.

Authorize, as part of its order, the creation of a trust or other mechanism to assure

(3) The [panel or] court shall provide to the [claimant or] plaintiff the option to choose either a lump sum or payments paid over a period of time.

(c) (1) If the advanced payment exceeds the liability of the person making it, [the arbitration panel or] the court [on appeal] may order such adjustments as justice may require under the [award or] verdict[,] including, where appropriate, contribution by other parties found to be liable.

(2) In no event shall an advance payment in excess of the liability of the person making it be repayable by the person receiving it.

11-108.

[(c) An award by the health claims arbitration panel in accordance with § 3- 2A -05 of this article

for damages in which the cause of action arose before January 1,2005, shall be considered an award for purposes of this section.]

[(d)] (c) (1) In a jury trial, the jury may not be informed of the limitation established under subsection (b) of this section.

11-109.

[(d) If a health claims arbitration panel awards future economic damages in accordance with § 3-2A-05 of this article for damages in which the cause of action arises before January 1,2005, the arbitration panel may order that future economic damages be paid in accordance with the provisions of subsection (c) of this section.]

SECTION 3. AND BE IT FURTHER ENACTED, That the laws of Maryland read as follows.

Article - Courts and Judicial Proceedings

8-306.

In a civil action in which a jury trial is permitted, the jury shall consist of AT LEAST 6 jurors.

SECTION 4. AND BE IT FURTHER ENACTED, That the laws of Maryland read as follows.

Article - Insurance

1-202.

This article does not apply to:

(3) an organization that:

(vii) pays the premium tax imposed by Title 6 of this article on all premiums allocable to this State for life insurance and health insurance in effect for residents of this State; [or]

(4) a voluntary noncontractual religious publication arrangement that:

(xii) provides the following verbatim written disclaimer as a separate cover sheet for any and all
documents distributed by or on behalf of the exempt arrangement, including applications, guidelines, promotional, or informational material and all periodic publications:

"Notice

This publication is not issued by an insurance company nor is it offered through an insurance company. It does not guarantee or promise that your medical bills will be published or assigned to others for payment. No other subscriber will be compelled to contribute toward the cost of your medical bills. Therefore, this publication should never be considered a substitute for an insurance policy. This activity is not regulated by the State Insurance Administration, and your liabilities are not covered by the Life and Health Guaranty Fund. Whether or not you receive any payments for medical expenses and whether or not this entity continues to operate, you are always liable for any unpaid bills."; OR

(5) THE MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN EXCEPT AS OTHERWISE PROVIDED IN TITLE 29 OF THIS ARTICLE.

TITLE 29. MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN

SUBTITLE 1. DEFINITIONS.

29-101.

(A) IN THIS TITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "APPROVED RATE" MEANS THE RATE APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH TITLE 11 OF THIS ARTICLE.

(C) "BOARD" MEANS THE BOARD OF DIRECTORS FOR THE MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN.

(D) II CEDING INSURER" MEANS A MEDICAL PROFESSIONAL LIABILITY INSURER THAT ELECTS TO ENTER INTO A REINSURANCE AGREEMENT AUTHORIZED BY THIS TITLE.

(E) "CESSION EFFECTIVE DATE" MEANS THE DATE IDENTIFIED IN A REINSURANCE AGREEMENT ON WHEN RISK IS TRANSFERRED TO THE PLAN BY THE CEDING INSURER.

(F) "FUND" MEANS THE MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN FUND.

(G) "MEDICAL PROFESSIONAL LIABILITY INSURER" MEANS AN INSURER THAT:

(1) HOLDS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER;

(2) IS NOT FORMED UNDER THE CAPTIVE INSURANCE LAWS OF ANY JURISDICTION OR THE FEDERAL RISK RETENTION ACT; AND

(3) ISSUES OR DELIVERS POLICIES OF MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THE STATE.

(H) "PLAN" MEANS THE MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN.

(I) "REINSURANCE AGREEMENT" MEANS A CONTRACT BETWEEN THE PLAN AND A CEDING INSURER THAT IS MADE IN ACCORDANCE WITH THIS TITLE.

(J) "STABILIZED RATE" MEANS A RATE THAT:

(1) IS DETERMINED BY THE PLAN AND APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH THIS TITLE; AND

(2) A CEDING INSURER MUST CHARGE IF THE CEDING INSURER ELECTS TO ENTER INTO A REINSURANCE AGREEMENT WITH THE PLAN.

SUBTITLE 2. MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN.

29-201.

(A) THERE IS A MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN CREATED AS A UNIT IN THE EXECUTIVE DEPARTMENT.

(B) THE PURPOSE OF THE PLAN IS:

(1) TO PROTECT THE PUBLIC WELFARE AND TO ASSURE THE CONTINUITY, AFFORDABILITY, AND ACCESSIBILITY OF HEALTH CARE FOR CITIZENS OF THE STATE; AND

(2) TO STABILIZE THE RATES APPLICABLE TO MEDICAL PROFESSIONAL LIABILITY INSURANCE BY:

(I) ALLOWING A MEDICAL PROFESSIONAL LIABILITY INSURER TO ISSUE MEDICAL PROFESSIONAL LIABILITY INSURANCE AT A RATE THAT IS LESS THAN ITS APPROVED RATE; AND

(II) MAKING FUNDS AVAILABLE TO THE MEDICAL PROFESSIONAL LIABILITY INSURER THROUGH REINSURANCE IN AN AMOUNT EQUAL TO THE DIFFERENCE BETWEEN THE PREMIUM EARNED BY THE APPLICATION OF THE CEDING INSURER'S STABILIZED RATE AND THE PREMIUM THAT WOULD HAVE BEEN EARNED BY APPLICATION OF THE CEDING INSURER'S APPROVED RATE.

(C) THE PLAN IS AN INDEPENDENT UNIT IN THE EXECUTIVE BRANCH OF STATE GOVERNMENT THAT FOR ADMINISTRATIVE AND BUDGETARY PURPOSES SHALL BE PLACED UNDER THE

29-202.

(A) THERE IS A BOARD OF DIRECTORS OF THE PLAN.

(B) THE PLAN SHALL OPERATE SUBJECT TO THE SUPERVISION AND CONTROL OF THE BOARD.

(C) THE BOARD SHALL BE COMPOSED OF 5 MEMBERS, INCLUDING:

(1) THREE MEMBERS APPOINTED BY THE GOVERNOR;

(2) ONE MEMBER APPOINTED BY THE PRESIDENT OF THE SENATE; AND

(3) ONE MEMBER APPOINTED BY THE SPEAKER OF THE HOUSE OF DELEGATES.

(D) OF THE THREE MEMBERS APPOINTED BY THE GOVERNOR, ONE SHALL HAVE EXPERIENCE AND EXPERTISE IN MEDICAL PROFESSIONAL LIABILITY INSURANCE MATTERS.

(E) A MEMBER OF THE BOARD MAY NOT BE EMPLOYED BY OR AFFILIATED WITH ANY ENTITY THAT OFFERS OR PROVIDES MEDICAL PROFESSIONAL LIABILITY INSURANCE TO HEALTH CARE PROVIDERS IN THE STATE.

(F) (1) THE TERM OF A MEMBER IS FOUR YEARS.

(2) THE TERMS OF MEMBERS ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS OF THE BOARD ON THE EFFECTIVE DATE OF THIS ACT.

(3) AT THE END OF A TERM, A MEMBER CONTINUES TO SERVE UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(4) A MEMBER WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES ONLY FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(5) A MEMBER MAY NOT SERVE MORE THAN 2 CONSECUTIVE TERMS.

(G) THE GOVERNOR MAY REMOVE A MEMBER FOR INCOMPETENCE OR MISCONDUCT.

(H) FROM AMONG THE MEMBERS, THE GOVERNOR SHALL APPOINT THE CHAIRMAN.

(I) A MAJORITY OF THE MEMBERS THEN SERVING ON THE BOARD IS A QUORUM.

(J) THE BOARD SHALL DETERMINE THE TIMES AND PLACES OF ITS MEETINGS.

(K) A MEMBER OF THE BOARD:

(1) MAY NOT RECEIVE COMPENSATION; BUT

(2) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

29-203.

(A) (1) WITH THE APPROVAL OF THE GOVERNOR, THE BOARD SHALL APPOINT AN EXECUTIVE DIRECTOR WHO SHALL BE THE CHIEF ADMINISTRATIVE OFFICER OF THE PLAN.

(2) IF THE BOARD DETERMINES THAT THE OPERATION OF THE PLAN MAY BE ADMINISTERED SUITABLY AND EFFICIENTLY BY A THIRD-PARTY, THE BOARD MAY, IN LIEU OF APPOINTING AN EXECUTIVE DIRECTOR, WITH THE APPROVAL OF THE GOVERNOR, ENTER INTO A CONTRACT, NOT TO EXCEED 5 YEARS IN DURATION, WITH A THIRD-PARTY TO ADMINISTER THE OPERATION OF THE PLAN UNDER THE CONTINUING DIRECTION OF THE BOARD.

(B) THE EXECUTIVE DIRECTOR SERVES AT THE PLEASURE OF THE BOARD.

(C) THE BOARD SHALL DETERMINE THE APPROPRIATE COMPENSATION FOR THE EXECUTIVE DIRECTOR, AS PROVIDED IN THE STATE BUDGET.

(D) THE EXECUTIVE DIRECTOR SHALL:

(1) MANAGE THE DAY TO DAY OPERATION AND OVERSIGHT OF THE PLAN IN CONFORMITY WITH THE DIRECTIONS OF THE BOARD;

(2) REPORT ON THE OPERATION OF THE PLAN TO THE BOARD;

(3) HIRE, WITH THE CONSENT OF THE BOARD, THE PERSONNEL NECESSARY TO CONDUCT THE BUSINESS OF THE PLAN; AND

(4) RETAIN, WITH THE CONSENT OF THE BOARD, PROFESSIONAL CONSULTANTS, INCLUDING ACTUARIES, ACCOUNTANTS, AUDITORS AND INVESTMENT ADVISERS.

SUBTITLE 3. MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN FUND.

29-301.

(A) THERE IS A MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN FUND.

(B) (1) THE FUND IS A CONTINUING NONLAPSING FUND THAT IS NOT SUBJECT TO §7-302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(2) SUBJECT TO SUBSECTION (G) OF THIS SECTION, ANY UNSPENT PORTIONS OF THE FUND MAY NOT BE TRANSFERRED OR REVERT TO THE GENERAL FUND OR ANY SPECIAL FUND OF THE STATE, BUT SHALL REMAIN IN THE FUND TO BE USED FOR THE PURPOSES SPECIFIED IN THIS TITLE.

(3) THE TREASURER SHALL HOLD AND THE COMPTROLLER SHALL SEPARATELY ACCOUNT FOR THE FUND.

(4) THE FUND SHALL BE INVESTED AND REINVESTED AT THE DIRECTION OF THE BOARD.

(5) ANY INVESTMENT EARNINGS SHALL BE RETAINED TO THE CREDIT OF THE FUND.

(C) THE FUND CONSISTS OF:

(1) MONEY APPROPRIATED BY THE STATE TO THE MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN FUND;

(2) INCOME FROM INVESTMENTS THAT THE BOARD MAKES OR AUTHORIZES ON BEHALF OF THE FUND;

(3) INTEREST ON DEPOSITS OR INVESTMENTS OF MONEY FROM THE FUND;

(4) MONEY COLLECTED BY THE BOARD AS A RESULT OF LEGAL OR OTHER ACTIONS TAKEN BY THE BOARD ON BEHALF OF THE FUND;

(5) MONEY DONA TED TO THE FUND; AND

(6) MONEY AWARDED TO THE FUND THROUGH GRANTS.

(D) THE GOVERNOR SHALL INCLUDE IN THE ANNUAL BUDGET FOR FISCAL YEAR2006AND FISCAL YEAR 2007 AN APPROPRIATION TO THE FUND.

(E) THE ASSETS OF THE FUND MAY BE USED ONLY:

(1) TO PAY THE ADMINISTRATIVE EXPENSES OF THE PLAN AND THE FUND, INCLUDING THE PURCHASE OF COMMERCIAL REINSURANCE BY THE PLAN; AND

(2) TO SATISFY THE CONTRACTUAL OBLIGATIONS ASSUMED BY THE PLAN UNDER REINSURANCE AGREEMENTS ISSUED BY THE PLAN IN ACCORDANCE WITH THIS TITLE.

(F) AT LEAST ANNUALLY, THE PLAN SHALL ACTUARIALLY DETERMINE AND ESTABLISH RESERVES WITHIN THE FUND FOR LOSSES ANTICIPATED UNDER REINSURANCE AGREEMENTS ISSUED BY THE PLAN.

(G) EACH SEPTEMBER 1 THE PLAN SHALL:

(1) DETERMINE THE AGGREGATE MAXIMUM CONTRACTUAL LIABILITY OF THE PLAN UNDER ALL REINSURANCE AGREEMENTS ISSUED BY THE PLAN, PLUS ALL INCURRED EXPENSES AND LIABILITIES OF THE PLAN; AND

(2) UNSPENT PORTIONS OF THE FUND THAT EXCEED THE AMOUNT DETERMINED SHALL REVERT TO THE GENERAL FUND.

SUBTITLE 4. REINSURANCE AGREEMENTS.

29-401.

(A) (1) THE PLAN IS AUTHORIZED TO ENTER INTO REINSURANCE AGREEMENTS WITH MEDICAL PROFESSIONAL LIABILITY INSURERS.

(2) ALL REINSURANCE AGREEMENTS ISSUED BY THE PLAN IN CALENDAR YEAR 2005 SHALL HAVE A CESSION EFFECTIVE DATE OF JANUARY 1, 2005 OR THE EFFECTIVE DATE OF THE LAST RATE INCREASE APPROVED FOR THE CEDING INSURER BY THE COMMISSIONER, WHICHEVER IS LATER IN TIME, REGARDLESS OF THE ACTUAL DATE ON WHICH THE REINSURANCE AGREEMENT IS ISSUED.

(B) THE PLAN AND THE COMMISSIONER SHALL ADOPT REGULATIONS THAT ESTABLISH:

(1) THE SCOPE OF THE RISKS ASSUMED BY A MEDICAL PROFESSIONAL LIABILITY INSURER THAT MAY BE CEDED TO THE PLAN;

(2) THE HEALTH CARE PROVIDERS, BY PROFESSION OR AREAS OF PRACTICE, WHOSE RATES ARE SUBJECT TO STABILIZATION UNDER REINSURANCE AGREEMENTS ISSUED BY THE PLAN;

(I) SHALL HAVE A TERM OF NOT MORE THAN ONE YEAR;

(II) MAY NOT HAVE A CESSION EFFECTIVE DATE PRIOR TO JANUARY 1, 2005;

(II MAY NOT ALLOW ANY RISK TO BE CEDED TO THE PLAN AFTER DECEMBER 31, 2007;

(IV) SHALL LIMIT THE LIABILITY OF THE PLAN TO:

1. THE DIFFERENCE BETWEEN THE PREMIUM EARNED BY THE APPLICATION OF THE CEDING INSURER'S STABILIZED RATE AND THE PREMIUM THAT WOULD HAVE BEEN EARNED BY THE APPLICATION OF THE CEDING INSURER'S APPROVED RATE; AND

2. INTEREST ON THE DIFFERENCE CALCULATED IN A MANNER DETERMINED BY

THE PLAN;

(V) SHALL CONTAIN A CLAUSE THAT PROVIDES THAT ALL OBLIGATIONS UNDER THE REINSURANCE AGREEMENT SHALL BE EXTINGUISHED AND RELEASED 6 YEARS FROM THE CESSION EFFECTIVE DATE OR BY DECEMBER 31, 2012, WHICHEVER IS EARLIER IN TIME, TO THE CEDING INSURER IN CONSIDERATION OF THE PLAN'S PAYMENT OF AN AMOUNT TO BE DETERMINED THROUGH A FORMULA DEVELOPED BY THE PLAN AND SET FORTH IN THE REINSURANCE AGREEMENT; AND

(VI) SHALL INCLUDE A CLAUSE THAT PLAINLY STATES THAT ALL DEBTS, OBLIGATIONS, AND LIABILITIES OF THE PLAN UNDER REINSURANCE AGREEMENTS ISSUED BY THE PLAN DO NOT CONSTITUTE DEBTS, OBLIGATIONS OR LIABILITIES OF THE STATE OR THE STATE'S AGENCIES, INSTRUMENTALITIES, OFFICERS, OR EMPLOYEES TO WHICH THE FAITH AND CREDIT OF THE STATE IS PLEDGED;

(3) PROCEDURES FOR CEDING INSURERS TO OBTAIN PAYMENTS FROM THE FUND UNDER REINSURANCE AGREEMENTS ISSUED BY THE PLAN;

(4) THE METHOD BY WHICH THE PLAN WILL DETERMINE THE STABILIZED RATE FOR A CEDING INSURER UNDER A REINSURANCE AGREEMENT ISSUED BY THE PLAN, PROVIDED THAT THE REGULATIONS SHALL REQUIRE THAT:

(I) A STABILIZED RATE MAY NOT BE LESS THAN THE APPROVED RATE IN EFFECT FOR THE CEDING INSURER AS OF DECEMBER 31,2004; AND

(II) THE APPLICATION OF THE STABILIZED RATES BY ALL CEDING INSURERS MAY NOT RESULT IN AN AGGREGATE LIABILITY TO THE FUND THAT EXCEEDS THE AMOUNT OF THE APPROPRIATIONS TO THE FUND, MINUS THE PROJECTED EXPENSES OF THE FUND; AND

(5) THE METHOD BY WHICH THE PLAN WILL DETERMINE STABILIZED RATES FOR A CEDING INSURER UNDER A REINSURANCE AGREEMENT ISSUED BY THE PLAN, PROVIDED THAT:

(I) THE REGULATIONS SHALL REQUIRE THAT:

1. A STABILIZED RATE MAY NOT BE LESS THAN THE APPROVED RATE IN EFFECT FOR THE CEDING INSURER AS OF DECEMBER 31, 2004; AND

2. THE APPLICATION OF THE STABILIZED RATES BY ALL

CEDING INSURERS MAY NOT RESULT IN AN AGGREGATE LIABILITY TO THE FUND THAT EXCEEDS THE AMOUNT OF THE APPROPRIATIONS TO THE FUND, MINUS THE PROJECTED EXPENSES OF THE FUND.

(II) THE REGULATIONS MAY AUTHORIZE DIFFERENT STABILIZED RATES FOR DIFFERENT HEALTH CARE PROVIDERS INSURED BY A CEDING INSURER, BASED UPON PROFESSION OR AREA OF PRACTICE.

(C) (1) ALL DEBTS, OBLIGATIONS, AND LIABILITIES OF THE PLAN, INCLUDING THE OBLIGATIONS ASSUMED BY THE PLAN UNDER REINSURANCE AGREEMENTS ISSUED BY THE PLAN, SHALL BE THE DEBTS, OBLIGATIONS, AND LIABILITIES OF THE PLAN AND THE FUND ONLY AND NOT OF THE STATE OR THE STATE'S AGENCIES, INSTRUMENTALITIES, OFFICERS, OR EMPLOYEES.

(2) A DEBT OR OBLIGATION OF THE PLAN, INCLUDING THE OBLIGATIONS ASSUMED BY THE PLAN UNDER REINSURANCE AGREEMENTS ISSUED BY THE PLAN, IS NOT A DEBT OF THE STATE ORA PLEDGE OF CREDIT OF THE STATE.

29-402.

(A) (1) BEFORE ANY REINSURANCE AGREEMENT BETWEEN THE PLAN AND A CEDING INSURER MAY BE ISSUED, THE PLAN SHALL SUBMIT THE REINSURANCE AGREEMENT TO THE COMMISSIONER FOR APPROVAL.

(2) THE COMMISSIONER SHALL REVIEW REINSURANCE AGREEMENTS SUBMITTED BY THE PLAN TO DETERMINE WHETHER THEY COMPLY WITH THE REQUIREMENTS OF THE REGULATIONS ADOPTED UNDER THIS SUBTITLE AND THE PURPOSES OF THIS TITLE.

(B) (1) BEFORE ANY STABILIZED RATE DETERMINED BY THE PLAN MAYBE IMPLEMENTED BY A CEDING INSURER, THE PLAN SHALL SUBMIT THE RATE TO THE COMMISSIONER FOR APPROVAL.

(2) THE COMMISSIONER SHALL REVIEW THE STABILIZED RATES SUBMITTED BY THE PLAN TO DETERMINE WHETHER THEY COMPLY WITH THE REQUIREMENTS OF THE REGULATIONS ADOPTED UNDER THIS SUBTITLE AND THE PURPOSES OF THIS TITLE.

29-403.

(A) IF A CEDING INSURER ENTERS INTO A REINSURANCE AGREEMENT WITH THE

PLAN, THE CEDING INSURER MAY ONLY CHARGE ITS STABILIZED RATE FOR ANY MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICY ISSUED BY THE CEDING INSURER AFTER THE CESSION EFFECTIVE DATE.

(B) To THE EXTENT THAT A CEDING INSURER HAS CHARGED AND COLLECTED PREMIUM IN EXCESS OF THE AMOUNT OF PREMIUM DUE BY THE APPLICATION OF ITS STABILIZED RATE:

(1) IF THE PREMIUM HAS BEEN PAID IN FULL, THE CEDING INSURER SHALL REFUND THE EXCESS TO ITS POLICYHOLDER WITHIN 60 DAYS OF THE ISSUANCE OF THE REINSURANCE AGREEMENT THAT SETS FORTH THE STABILIZED RATE; AND

(2) IF THE PREMIUM IS BEING PAID IN ACCORDANCE WITH AN APPROVED INSTALLMENT PLANS, THE CEDING INSURER SHALL CREDIT THE EXCESS, IN FULL, TO THE NEXT INSTALLMENT PAYMENT DUE FROM THE POLICYHOLDER.

(C) A CEDING INSURER THAT CONDUCTS BUSINESS AS A MUTUAL COMPANY MAY NOT ISSUE A DIVIDEND DURING THE TERM OF A REINSURANCE AGREEMENT.

SUBTITLE 5. REPORTS.

29-501.

(A) ON OR BEFORE SEPTEMBER 1 OF EACH YEAR, THE PLAN SHALL SUBMIT A REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF DELEGATES, AND THE COMMISSIONER THAT INCLUDES:

(1) A SUMMARY OF THE PLAN'S ACTIVITIES;

(2) A STATEMENT OF THE LOSSES ANTICIPATED UNDER REINSURANCE AGREEMENTS ISSUED BY

THE PLAN;

(3) A STATEMENT OF CLAIMS MADE AGAINST THE PLAN;

(4) A STATEMENT AS TO THE VALUE OF THE FUND AND THE RESERVES WITHIN THE FUND;

(5) A STATEMENT OF EXPENSES INCURRED BY THE PLAN; AND

(6) ANY OTHER INFORMATION THAT THE PLAN CONSIDERS APPROPRIATE OR THAT THE COMMISSIONER REQUIRES.

(B) ON OR BEFORE SEPTEMBER 1 OF EACH YEAR, THE PLAN SHALL SUBMIT TO THE GOVERNOR A RECOMMENDATION BY THE PLAN REGARDING THE AMOUNT OF MONEY TO BE APPROPRIATED TO THE FUND IN THE NEXT FISCAL YEAR.

29-502.

THE PLAN IS SUBJECT TO § 19-112 OF THIS ARTICLE.

Article - State Finance and Procurement

11-203.

(a) Except as provided in subsection (b) of this section, this Division does not apply to:

(1) procurement by:

(xix) the Maryland Developmental Disabilities Administration of the Department of Health and Mental Hygiene for family and individual support services, and individual family care services, as those terms are defined by the Department of Health and Mental Hygiene in regulation; AND

(XX) THE MARYLAND MEDICAL PROFESSIONAL LIABILITY RATE STABILIZATION PLAN ESTABLISHED UNDER TITLE 29 OF THE INSURANCE ARTICLE.

SECTION 5. AND BE IT FURTHER ENACTED, That Section(s) 3-2A-01(b) and (e) and Section(s) 3-2A-03 through 3-2A-07, inclusive, of Article - Courts and Judicial Proceedings of the Annotated Code of Maryland be repealed.

SECTION 6. AND BE IT FURTHER ENACTED, That Section(s) 3-2A-01(c), (d), and (f) through (m), respectively, of Article - Courts and Judicial Proceedings of the Annotated Code of Maryland be renumbered to be Section(s) 3-2A-01 (b), (c), and (d) through (k), respectively.

SECTION 7. AND BE IT FURTHER ENACTED, That §§ 3-2A-06E and 3-2A-08A of the Courts Article, as enacted by Section 1 of this Act, shall be construed to apply only prospectively and may not be applied or interpreted to have any effect on or application to any case filed before the effective date of this Act.

SECTION 8. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall be construed to apply only prospectively to an initial complaint filed on or after the effective date of this

Act.

SECTION 9. AND BE IT FURTHER ENACTED, That the terms of the initial members of the Board of Directors for the Maryland Medical Professional Liability Reinsurance Program shall expire as follows:

(1) 1 of the members appointed by the Governor on the first anniversary of the effective date of this Act;

(2) The member appointed by the Speaker of the House on the second anniversary of the effective date of this Act;

(3) The member appointed by the President of the Senate on the third anniversary of the effective date of this Act;

(4) The remaining 2 members appointed by the Governor on the fourth anniversary of the effective date of this Act.

SECTION 10. AND BE IT FURTHER ENACTED, That on January 1, 2013, any money that remains in the Maryland Medical Professional Liability Rate Stabilization Plan Fund shall be transferred to the General Fund of the State.

SECTION 11. AND BE IT FURTHER ENACTED, That on January 1, 2013, in accordance with § 1 0- 702 of the State Government Article, all records of the Maryland Medical Professional Liability Rate Stabilization Plan shall be transferred to the State Archives and all other property of the Maryland Medical Professional Liability Rate Stabilization Plan shall be transferred to the Board of Public Works.

SECTION 12. AND BE IT FURTHER ENACTED, That if any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of this Act which can be given effect without the invalid provision or application, and for this purpose the provisions of this Act are declared severable.

SECTION 13. AND BE IT FURTHER ENACTED, That the Director of the Health Claims Arbitration Office shall notify in writing the Department of Legislative Services, 90 State Circle Annapolis, Maryland 21401 on the date when there are no claims pending before the Health Claims Arbitration Office.

SECTION 14. AND BE IT FURTHER ENACTED, That the State has placed a high priority on improving patient safety in Maryland hospitals. Recent efforts have included the Maryland Health Care Commission's designation of the Maryland Patient Safety Center with funding support from the

Health Services Cost Review Commission, adoption of enhanced patient safety regulations by the Department of Health and Mental Hygiene, and new patient safety criteria for hospital capital expenditures under the certificate of need program. In order to further these efforts, the Health Services Cost Review Commission shall include a reasonable amount of additional funding in hospital approved rates for hospital patient safety related initiatives and infrastructure.

SECTION 15. AND BE IT FURTHER ENACTED, That an insurer, nonprofit health service plan, health maintenance organization, dental plan organization, or any other person that provides health benefit plans subject to regulation by the State may not reimburse an obstetrician, neurologist, orthopedist, or emergency room physician in an amount less than the global fee, capitation rate, or per unit sum or rate being paid to the health care practitioner on November 1, 2004.

SECTION 16. AND BE IT FURTHER ENACTED, That Section 10 of this Act shall take effect January 1, 2005. It shall remain effective for a period of 3 years, and at the end of December 31, 2007, with no further action required by the General Assembly, Section 11 of this Act shall be abrogated and of no further force and effect.

SECTION 17. AND BE IT FURTHER ENACTED, That Sections 2, 4, and 5 of this Act shall take effect contingent on the written notification of the Director of the Health Claims Arbitration Office sent to the Department of Legislative Services, 90 State Circle Annapolis, Maryland 21401 that there are no claims pending before the Health Claims Arbitration Office.

SECTION 18. AND BE IT FURTHER ENACTED, That Section 4 of this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three- fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted. It shall remain in effect for a period of eight years and, at the end of December, 2012, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

SECTION 19. AND BE IT FURTHER ENACTED, That, subject to Sections 16, 17, and 18 of this Act, this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.